

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12032 CERTIFICATE OF DEATH

12013

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b OF INSTITUTION <i>25 Blenche St.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>A. d. Co.</i>		
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				
						d. STREET ADDRESS <i>25 Blenche St</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Mary Constantine Adams</i>		First <i>Mary</i>	Middle <i>Constantine</i>	Last <i>Adams</i>	4. DATE OF DEATH <i>12 24 1956</i>	Month <i>12</i>	Day <i>24</i>	Year <i>1956</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Cub.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-15-1908</i>		9. AGE (In years from birthday) <i>78</i>	IF UNDER 1 YEAR yrs. <i>0</i>	IF UNDER 24 HRS. Months <i>0</i>	Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>School Teacher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ed. of Educator</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>				
13. FATHER'S NAME <i>Charles Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Emma Parker</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No—Unknown)		16. SOCIAL SECURITY NO. <i>220-36-9609</i>		17. INFORMANT <i>Walter Adams - 25 Blenche St. Annapolis</i>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>156.1</i>		DUE TO <i>Exacerbation of the lung</i>				INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b)</i>										
DUE TO <i>(c)</i>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)								
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		Month <i>10</i>	Day <i>16</i>	Year <i>1956</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>12-16-18</i>	(County) <i>12-16-18</i>	(State) <i>12-16-18</i>	
21. I certify that I attended the deceased from <i>10-16-56</i> , 19 <i>56</i> , to <i>12-16-18</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12-23-56</i> , 19 <i>56</i> , and that death occurred at <i>5:50</i> P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>62 Crookshank</i>				
ACTUAL SIGNATURE <i>G.T. All</i>						DATE SIGNED <i>12-23-56</i>				
PHYSICIAN'S NAME (Type) <i>A T Alley</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-27-56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) <i>Annapolis, Md.</i>		(State) <i>Annapolis, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr. - Annapolis, Md.</i>		ADDRESS <i>William Reese, Jr. - Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>Wm French</i>		24b. REGISTRAR'S SIGNATURE <i>Wm French</i>				
									E.J.	

CERTIFICATE OF DEATH

BUREAU N.Y.

DEC 31 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12033 CERTIFICATE OF DEATH

Reg. Dist. No.

12014

1. PLACE OF DEATH o. COUNTY <i>a.a.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>a.a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	c. LENGTH OF STAY IN lb <i>10 days</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>911 Wells Ave.</i>		d. STREET ADDRESS <i>911 Wells Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>B.</i>	Last <i>Allen</i>
4. DATE OF DEATH	Month <i>12</i>	Day <i>7</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-14-1902</i>
9. AGE (In years lost, birthday) <i>54 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>	11. KIND OF BUSINESS OR INDUSTRY <i>House Building</i>	12. BIRTHPLACE (State or foreign country) <i>PENNA.</i>
13. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	14. MOTHER'S MAIDEN NAME <i>BESSE CHRISTIAN</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Mabel Mason Allen</i>	Address <i>(2)</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>161X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i> DUE TO <i>(c)</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month <i>19</i>	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i>	(County) <i>Md.</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>12-14-56</i> , 19 <i>—</i> , to <i>12-7-56</i> , 19 <i>—</i> , that I last saw the deceased alive on <i>12-7-56</i> , 19 <i>—</i> , and that death occurred at <i>6 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. L. Wharfdale</i> ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i> DATE SIGNED <i>12/8/56</i>			
PHYSICIAN'S NAME (Type)	<i>E. L. Wharfdale</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-9-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Rogers Family Plot</i>	22d. LOCATION (City, town, or county) <i>Annapolis, Md.</i> (State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor, Inc. Annapolis, Md.</i>	ADDRESS <i>Annapolis, Md.</i>	24a. REC'D BY REGISTRAR <i>Frank</i>	24b. REGISTRAR'S SIGNATURE <i>Frank</i>

## 130-2. CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
DECEMBER 12 1956				
BUREAU V. S.				
RECEIVED				

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12015

## 12034 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		
<i>A. A.</i> MARYLAND		<i>Md.</i> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>Baltimore</i>	<i>life</i>	<i>Baltimore</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
<i>Plaza Manor Conv. Hosp.</i>	<i>5-B. Elmer Court</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>H. F.</i>	Middle <i>Anderson</i>	Last. <i>Anderson</i>	4. DATE OF DEATH <i>Dec. 6 1956</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>Widowed</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <i>Divorced</i>	8. DATE OF BIRTH <i>1887</i>	9. AGE (In years lost/birthday) <i>9 yrs.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>A. A. Co.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Mr. Adams</i>	14. MOTHER'S MAIDEN NAME <i>Mary (Unknown)</i>			Address <i>Ormet Anderson Baltimore</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Ormet Anderson Baltimore</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b) Hypertension</i> DUE TO <i>(c)</i> DUE TO <i>—</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. —————— p. m. ——————	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>	20f. (City or town) <i>—</i> (County) <i>—</i> (State) <i>—</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>7:30 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. F. Manuzak</i> M.D. <i>901 Edgely Rd</i> DATE SIGNED <i>8 Dec 56</i> PHYSICIAN'S NAME (Type) <i>H. F. MANUZAK</i> ADDRESS <i>Glen Burnie, Md</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec. 9 1956</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>	(State) <i>Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Hamon Baltimore</i>		ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR <i>Dec. 10 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Wm J French</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, Page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILLIAM D. SULLIVAN, SECRETARY OF DEFENSE - BUREAU OF THE BUDGET

DEC 11 1956

DEC 11 1956  
REGEL V EEU

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12016

## 12056 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>A A</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Shady Side</i>		c. LENGTH OF STAY IN lb <i>12 hrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>		d. STREET ADDRESS <i>X</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <i>ALLAN</i>	Middle <i>ASHLAND</i>	Last <i>ARMISTER</i>	4. DATE OF DEATH <i>12/1/56</i>	Month <i>12</i>	Day <i>1</i>	Year <i>1956</i>
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5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>JAN 19, 1886</i>	9. AGE (in years lost birthday) <i>70 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	11. BIRTHPLACE (State or foreign country) <i>Friendship Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
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13. FATHER'S NAME <i>John ARMISTER</i>	14. MOTHER'S MAIDEN NAME <i>Norfolk</i>	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>213 360 253</i>	17. INFORMANT <i>Ruth ARMISTER, Lothian, Md.</i>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>260 X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { DUE TO (b) Coronary occlusion DUE TO (c) Diabetes Mellitus	Immediately
	Immediately
	7 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>probably arteriosclerosis</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>None</i>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>None</i>	(County)	(State)

21. I certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_\_, and that death occurred at 8:15A M, from the causes and on the date stated above.

ACTUAL SIGNATURE *F.D. Hendricks M.D.* ADDRESS (Street, city or town, state) *Shady Side, Md.* DATE SIGNED *12-21-56*  
PHYSICIAN'S NAME (Type) *F.D. Hendricks* Shady Side, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>12/22/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Lyder's</i>	22d. LOCATION (City, town, or county) <i>Hfd 1050</i>	(State) <i>MD</i>
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty</i>	ADDRESS <i>Galesville Md</i>	24a. REC'D BY REGISTRAR <i>J. J. Hardisty</i>	24b. REGISTRAR'S SIGNATURE <i>J. J. Hardisty</i>
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WISCONSIN STATE LIBRARY - GALLIVANCE 18

CERTIFICATE OF DEATH

RECEIVED

SEARCHED

INDEXED

SERIALIZED

FILED

BUREAU V. S.

DEC 20 1944

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12018  
28

12057

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Worcester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Newark</b>		d. STREET ADDRESS <b>Rural</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Levin</b>	Middle <b></b>	Last <b>Ayers</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>27</b>	Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNK <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1884</b>	9. AGE (In years less birthday) <b>77 78</b>	IF UNDER 1 YEAR Months <b></b>	IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unk. Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming Unk.</b>		11. BIRTHPLACE (State or foreign country) <b>Berlin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Unknown Isaac Ayers</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Minty Holland</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type no. or unknown) <b>Unk. No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT John Ayers, Newark, Address Md. <b>Crownsville Hospital Records</b>		INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>177X</b>		Pneumonia, Terminal						
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Senility and Malnutrition						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Enlargement of prostate, probably carcinoma</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				
21. I certify that I attended the deceased from _____ 7/10 _____, 19 56, to 12/27, 19 56, that I last saw the deceased alive on _____ 12/27, 19 56, and that death occurred at 6:45 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i> PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp</b>				ADDRESS (Street, city or town, state) <b>Crownsville, Maryland</b>		DATE SIGNED <b>12/28/56</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1 - 1 - 57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) <b>Berlin, Worcester Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Stewart Funeral Home Bel Air, Md.</i>		ADDRESS <b>101 N. Main Street, Bel Air, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>12/28/56</b>		24b. REGISTRAR'S SIGNATURE <i>J. Stewart Funeral Home Bel Air, Md.</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH—MANITOBA

1

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12019

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ANNE ARUNDEL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		d. STREET ADDRESS <b>12 REVELL ST.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12 REVELL ST.</b>				e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>ERIKA</b>	Middle <b>BAEUMKER</b>	Last <b>BAEUMKER</b>	4. DATE OF DEATH <b>DEC. 28 1956</b>	Month Day Year			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 1, 1896</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MEDICAL DOCTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MEDICINE</b>		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b> LANSBARG ON THE WARTHE				
13. FATHER'S NAME <b>FRANZ BEHREND</b>		14. MOTHER'S MAIDEN NAME <b>ANNA REISSER</b>		12. CITIZEN OF WHAT COUNTRY? <b>GERMANY</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ADOLPH E. BAEUMKER #1 (HUSBAND)</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>162x</b>		INTERVAL BETWEEN ONSET AND DEATH <b>June 56</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO <b>lung</b>	(b) <b>Metastases in mediastinum</b>		DUE TO <b>6 month 15 day</b>			
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>45 Franklin St. Annapolis, Md.</b>	20f. (City or town) <b>Annapolis</b>	(County) <b>Md.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>12-28-56</b> , 1956, to <b>12-28-56</b> , 1956, and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>45 Franklin St. Annapolis, Md.</b>				DATE SIGNED		
ACTUAL SIGNATURE <b>Edith Rosler</b>	M.D.							
PHYSICIAN'S NAME (Type) <b>EDITH ROPLER M.D.</b>	45 FRANKLIN ST. ANNAPOLIS,							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>12-31-56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>ST. MARY'S CEMETERY</b>	22d. LOCATION (City, town, or county) <b>ANNAPOLIS MD</b>	(State) <b>Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR SON ANNAPOLIS MD.</b>	ADDRESS	24a. REC'D BY REGISTRAR <b>12/31/56</b>		24b. REGISTRAR'S SIGNATURE <b>J. M. TAYLOR</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached from the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12020

12058

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>3 mo. 28 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY</b>		d. STREET ADDRESS <b>CROWNSVILLE, MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Last Name BARNES</b>		Middle <b>GEORGE</b>	Last <b>W.</b>	4. DATE OF DEATH <b>12-21</b>	Month	Day	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>8-23-1892</b>	9. AGE (In years lost birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Barnes</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Grooms</b>		Address <b>Crownsville, Md.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>- - - - -</b>		16. SOCIAL SECURITY NO. <b>Hospital Record</b>		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute and Congestive Heart Failure</b> DUE TO 023X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Aortitis - Luetic</b> DUE TO (c) <b>Cardiac Asthma</b> INTERVAL BETWEEN ONSET AND DEATH <b>- - - - -</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that I attended the deceased from <b>8-24</b> , 19 <b>56</b> to <b>12-21-56</b> , 19 <b>56</b> that I last saw the deceased alive on <b>12-21</b> , 19 <b>56</b> , and that death occurred at <b>11:00 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b> ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>12-21-56</b>	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		Month <b>a. j.</b>	Day <b>19</b>	Year <b>1956</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>- - - - -</b>	20f. (City or town) <b>Crownsville</b> (County) <b>Md.</b> (State) <b>12-21-56</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b> (State) <b>12-26-1956</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mrs. Katie R. Williams</b>		ADDRESS <b>222 N. Schroeder St.</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 26 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. M. Joyce</b>	

## MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF DEATH

## CERTIFICATE OF DEATH

NUMBER

NAME

AGE

SEX

MATERIAL

DEATH DATE

TIME

CAUSE

DEATH

TIME

RECEIVED  
BUREAU V. S.

DEC 29 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12059

## CERTIFICATE OF DEATH

12021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel Co.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>AA</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>		c. LENGTH OF STAY IN 1b <b>Months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn,</b>		d. STREET ADDRESS <b>505 Taney Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>505 Taney Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Charles</b>		First <b>W.</b>	Middle <b>Barnhart</b>	4. DATE OF DEATH <b>Dec 15 1956</b>	Month <b>Dec</b>	Day <b>15</b>	Year <b>1956</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/22/1861</b>	9. AGE (In years last birthday) <b>92 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>?</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Walker</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>		Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443 X</b>		<i>Hypertension &amp; cardiac vascular disease.</i>				INTERVAL BETWEEN ONSET AND DEATH <b>3 years.</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO <i>None</i>		(c)					
DUE TO <i>None</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>None</b> 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) <b>None</b>		(County) <b>None</b>	(State) <b>None</b>
21. I certify that I attended the deceased from <b>6/3</b> , 19 <b>56</b> , to <b>Dec 15, 1956</b> , that I last saw the deceased alive on <b>Dec 15, 1956</b> , and that death occurred at <b>1:30 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Dec. 15, 56</b> DATE SIGNED <b>302 Patapsco Ave.</b>			
ACTUAL SIGNATURE <b>Philip W. Keister</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>J. R. Yuan</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/19/56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Husbands Cemetery</b>		22d. LOCATION (City, town, or county) <b>Somerset, Pa.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Homes</b>		ADDRESS <b>130 E. Fort Ave. #30</b>		24a. REC'D BY REGISTRAR DATE <b>17 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mr. Whetton</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 9/55

UREAU Y.

1956 71-53

9901

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12022

## 12036 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		Anne Arundel		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ch. A. General Hosp.</i>		d. STREET ADDRESS <i>614 - 3rd Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>James Columbus Blunt</b>		First	Middle	Last	4. DATE OF DEATH Month Day Year <b>Nov 13 1956</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-15-1922</b>		9. AGE (In years (pt=birthday) yrs.) <b>34</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cement Finisher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>East Fort, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Charles Blunt</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Ellen Hall</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <b>Yes W.W. II</b>		16. SOCIAL SECURITY NO. <b>220-26-6369</b>		17. INFORMANT <i>Elizabeth Blunt - 614 3rd St. Annapolis</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b)		<b>Massive Cerebral Hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
		DUE TO (c)		<b>Hypertensive Cerebral Disease Grade IV</b>		<b>3 yrs</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>37 Robert Street</i>	(County) <i>Annapolis, Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <b>12/11</b> , 1956, to <b>12/13</b> , 1956, that I last saw the deceased alive on <b>12/13</b> , 1956, and that death occurred at <b>9:30 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>37 Robert Street, Annapolis, Md.</b>		
ACTUAL SIGNATURE <i>Theodore H. Johnson Jr.</i>		M.D.				DATE SIGNED <b>12/13/56</b>		
PHYSICIAN'S NAME (Type) <b>Dr. THEODORE H. JOHNSON</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-18-56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Annapolis National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Md.</b>		(State) <i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Resett - Annapolis, Md.</i>		ADDRESS <i>100 E. Pitt Street, Annapolis, Md.</i>		24a. REC'D BY REGISTRAR DATE <b>DEC 26 1956</b>		24b. REGISTRAR'S SIGNATURE <i>John J. Lynch</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DETERMINANT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

DECEASED

BUREAU V. S.

DEC 26 1966

RECEIVED

12024  
20

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

12069

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Anne Arundel MARYLAND Tracy	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	Maryland Anne Arundel Tracy 2nd X
HOSPITAL OR INSTITUTION OR STREET ADDRESS	LENGTH OF STAY (In this place)	STREET ADDRESS	(If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
S. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	8. DATE OF BIRTH Aug 2, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE last birthday 70 yrs.
13. FATHER'S NAME Charles Stanley Bowen		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. _____	14. MOTHER'S MAIDEN NAME Sarah Hall
17. INFORMANT & ADDRESS Mr Charles Bowen, Tracy MD		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 002X IMMEDIATE CAUSE (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		John Brumia Old Z.B.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Has been at Sanatorium		INTERVAL BETWEEN ONSET AND DEATH 2 wks 2 yrs	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) Owings Mill	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) Owings Mill MD	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____ Owings Mill	
22. I hereby certify that I attended the deceased from 11/24, 1956, to 12/2, 1956, that I last saw the deceased alive on 12/1, 1956, and that death occurred at 10:30 A.M. from the causes and on the date stated above. SIGNATURE H.W. Ward			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/4/56	NAME OF CEMETERY OR CRYPTORY Friendship
24. REC'D BY REGISTRAR DATE 12/3/56		REGISTRAR'S SIGNATURE Grace L. Hatchett	LOCATION (City, town, or county) Friendship Md
			ADDRESS (Street, city, town, state) Elm St. Williamsburg
			DATE SIGNED 12/3/56
			ADDRESS Wm H. Hutchinson

DEPARTMENT OF HEALTH-EDUCATION AND WELFARE

CERTIFICATE OF DEATH

DEATH CERTIFICATE

REGISTRATION FORM

DEATH CERTIFICATE

18

REGISTRATION FORM

REGISTRATION  
FORM

REGISTRATION FORM

BUREAU V.

DEC 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12037 CERTIFICATE OF DEATH

12025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>AA</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis, Md USNH</i>		c. LENGTH OF STAY IN 1b <i>2 months</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		d. STREET ADDRESS <i>82 Conduit Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U.S. Naval Hospital</i>									
3. NAME OF DECEASED (Type or print) <i>Genevieve</i>		First <i>(n)</i>	Middle <i>BRANSON</i>	Last	4. DATE OF DEATH <i>December 25</i>	Month <i>1956</i>	Day	Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Cau.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>12-25-07</i>	9. AGE (In years lost birthday) yrs. <i>49</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i>	Days <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i> </i>		11. BIRTHPLACE (State or foreign country) <i>N.J.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>Thomas Francis Devlin</i>		14. MOTHER'S MAIDEN NAME <i>Johanna (n) Daley</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. —		17. INFORMANT <i>U.S. Naval Records</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>153X</i>		Malnutrition, severe		INTERVAL BETWEEN ONSET AND DEATH 6 mo.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Adenocarcinoma, colon with Metastasis, multiple</i>				Indef.					
DUE TO <i>(c)</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i> </i>		20f. (City or town) <i> </i>		(County) <i> </i>	(State) <i> </i>
21. I certify that I attended the deceased from <i>10-29</i> , 19 <i>56</i> , to <i>12-25</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12-25-56</i> , 19 <i>56</i> , and that death occurred at <i>3:10 a.m.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i> </i>					DATE SIGNED
ACTUAL SIGNATURE <i>Robert A Sherry</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Robert A SHERRY</i>		LT. MC USNR		U.S. Naval Hospital, Anna. Md. 12-26-56					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-28-56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Arlington National</i>		22d. LOCATION (City, town, or county) <i>Arlington Va.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Son Annapolis Md</i>		ADDRESS <i> </i>		24a. REC'D BY REGISTRAR DATE <i>12-27-56</i>		24b. REGISTRAR'S SIGNATURE <i>John M. Taylor Son Annapolis Md</i>			

CERTIFICATE OF DEATH

BUREAU X-5  
RECEIVED  
DEC 28 1956

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4

may be received by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13101

## 12061 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNA ARUNDEL, JESSUPS</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Jessups, Md.</b>		c. LENGTH OF STAY IN lb <b>17 Mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FREDERICK</b>		d. STREET ADDRESS <b>457 W. South Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Maryland House of Correction</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Albert</b>	Middle <b>Monroe</b>	Last <b>Bruchey</b>	4. DATE OF DEATH <b>December 17 1956</b>	Month <b>December</b>	Day <b>17</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>March 9, 1906</b>	9. AGE (In years last birthday) <b>50</b>	IF UNDER 1 YEAR Months <b>50</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>		11. BIRTHPLACE (State or foreign country) <b>UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>David Bruchey</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hann</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriolar Nephrosclerosis with generalized edema</b> INTERVAL BETWEEN ONSET AND DEATH 446 X DUE TO <b>10 months</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. _____ p. m. _____	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____	(County) _____	(State) _____	
21. I certify that I attended the deceased from <b>July 8, 1955</b> , to <b>December 17, 1956</b> , that I last saw the deceased alive on <b>December 17, 1956</b> , and that death occurred at <b>7:25 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Robert B Taylor</i>	M.D.		ADDRESS (Street, city or town, state) <b>Maryland House of Correction</b>		DATE SIGNED <b>12-18-56</b>		
PHYSICIAN'S NAME (Type) <b>Jessup Rd</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>20 Dec 1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Olivet Cemetery</b>	22d. LOCATION (City, town, or county) <b>Frederick Maryland</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>M. L. Etchison &amp; Son</i>		ADDRESS <b>Frederick Md</b>	24a. REC'D BY REGISTRAR DATE <b>11/10/57</b>	24b. REGISTRAR'S SIGNATURE <b>Clare Lachus</b>			
VS A15 (4) 15M 9/55							

## CERTIFICATE OF DEATH

500-200-10

NAME OF DECEASED	AGE	SEX	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFICATE NUMBER
BUREAU V. S.						
RECEIVED						
JAN 10 1957						

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12026

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information or removal.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>AA</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Severn</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Thompson Ave</b>		d. STREET ADDRESS <b>Thompson Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Louis John Buddenbohn</b>		First	Middle	Last	4. DATE OF DEATH <b>Dec. 22, 1956</b>	Month	Day	Year <b>19</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 99 1915</b>	9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>National Plastics</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Charles Buddenbohn</b>			14. MOTHER'S MAIDEN NAME <b>Bertha Hall</b>			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-18-0889</b>		17. INFORMANT <b>Mrs Louise Buddenbohn, same as 2</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Self inflicted Strangulation</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>Deceased tied a rope around his neck and fastened it to a rafter</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased tied a rope around his neck and fastened it to a rafter</b>						
20c. TIME OF INJURY Month, Day, Year <b>10:50 am 12/22/56</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Severn, AA Co. Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>		DATE SIGNED <b>12/22/56</b>						
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/26/56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Glen Haven Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping and Kirkley</i>		ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 12/26/1956</b>		24b. REGISTRAR'S SIGNATURE <i>S. J. Kelly</i>		

HAWAIIAN STATE GOVERNMENT - VOLUME 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.  
RECEIVED  
DEC 26 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12027  
24

## 12063 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>ANNE ARUNDEL MARYLAND</i>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>RIVIERA BEACH</i>	<i>14 YEARS</i>	<i>RIVIERA BEACH</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
<i>MERDOW ROAD</i>		<i>MEADOW Rd.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	<i>CHARLES</i>	<i>Louis</i>	<i>CHAMBERS</i>
4. DATE OF DEATH	Month	Day	Year
	<i>DEC.</i>	<i>2</i>	<i>1956</i>
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
<i>MALE</i>	<i>WHITE</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>MAY 31, 1902</i>
9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
<i>56 yrs.</i>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>ROLLER</i>		<i>TIN MILL</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>MARYLAND</i>		<i>U.S.A.</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>P</i>		<i>Family - SAME</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
<i>No</i>		<i>Address</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>immediate</i>	
<i>CORONARY THROMBOSIS</i>			
420.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.			
(b) DUE TO		<i>30 MONTHS</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
<i>J. Brady Smith</i>		<i>Riviera Beach, MD. 12/21/56</i>	
PHYSICIAN'S NAME (Type)		<i>J. BRADY SMITH</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<i>12-5-56</i>		22c. NAME OF CEMETERY OR CREMATORIAL	
<i>RIVERA BEACH</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>McClenny Funeral Home</i>		24a. REC'D BY REGISTRAR DATE	
		<i>REG 5 1956</i>	
		24b. REGISTRAR'S SIGNATURE	
		<i>L.J. DeAlba</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DEPARTMENT OF HEALTH - CALIFORNIA

## CERTIFICATE OF DEATH

BUREAU V.

DEC 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be received by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12038 CERTIFICATE OF DEATH

12028  
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTRY <i>Gambrell</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>An</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis, Md</i>		c. LENGTH OF STAY IN 1b <i>4 Days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SEVERN, MD</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel Gen. Hospital</i>		d. STREET ADDRESS <i>RFD #1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>FRANK</i>		First	Middle	Last	4. DATE OF DEATH <i>December 4 1956</i>	Month	Day	Year
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/1/91</i>	9. AGE (In years last birthday) <i>65 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Plumber (ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Crownsville St. Hosp.</i>		11. BIRTHPLACE (State or foreign country) <i>WASHINGTON STATE</i>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>578-10-7919</i>		17. INFORMANT <i>Mrs. Bertha McCosand</i>		Address <i>Pt. 1 Severn, MD</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		DUE TO <i>Cerebral hemorrhage</i>				INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>31 Southgate Dr Annapolis</i>	(County) <i>Md.</i>	(State) <i>1956</i>
21. I certify that I attended the deceased from <i>12/1</i> , 1956, to <i>12/4</i> , 1956, that I last saw the deceased alive on <i>12/6</i> , 1956, and that death occurred at <i>705 Pt. 1</i> M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Maurice F. Klawans</i>		ADDRESS (Street, city or town, state) <i>31 Southgate Dr Annapolis</i>		DATE SIGNED <i>1956</i>				
PHYSICIAN'S NAME (Type) <i>MAURICE F. KLAWANS, MD</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Dec. 7, 1956</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Church of God Cem.</i>			22d. LOCATION (City, town, or county) <i>Gambrell</i>			(State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>T. J. Light</i>		ADDRESS <i>Glen Burnie, Md</i>		24a. REC'D BY REGISTRAR <i>DEC 6 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Dr. Frank J. French</i>		

## THE STATE OF MARYLAND - BALTIMORE CITY

## CERTIFICATE OF DEATH

DECEMBER 1956

BUREAU V.

DEC 6 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12029  
74

12064

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be signed by the hospital or attending physician  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director.

VS A1S (4)  
15M 9/55

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Anne Arundel Maryland		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 6 yrs	
Green Burnie Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Green Burnie Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 117 ROUTE 2 HAMMERSLEE Bench		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Austin Litzinger Coulbourne		4. DATE OF DEATH Dec. 22 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 19, 1917
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (in years last birthday) 39 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTOMOTIVE EQUIP.		10b. KIND OF BUSINESS OR INDUSTRY AUTOMOTIVE	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME SEWARD L. COULBOURNE		14. MOTHER'S MAIDEN NAME Lucie Egle Hart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 198X		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Anna Coulbourne Some	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 198X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c)  DUE TO		INTERVAL BETWEEN ONSET AND DEATH 17 mos.	
Metastasized to lungs & liver			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 19, 1956, to Dec 22, 1956, that I last saw the deceased alive on Dec 22, 1956, and that death occurred at 8:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Physician's Name (Type) CHARLES L. BELL JR.		ADDRESS (Street, city or town, state) M.D. Linthicum DATE SIGNED 12/22/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec 24, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL CEDAR Hill Cemetery		22d. LOCATION (City, town, or county) Anne Arundel Co., Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE George J. Gonsalves		24a. REC'D BY REGISTRAR DATE 12/22/56	
ADDRESS 4501 Ritchie Hwy		24b. REGISTRAR'S SIGNATURE L. J. Bell Jr.	

## CERTIFICATE OF DEATH

RECEIVED  
BUREAU V. S.  
DEC 23 1956

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12030

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12065

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending". In pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>AA</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>		c. LENGTH OF STAY IN lb <b>15 yrs.</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Clark Station</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Joseph</b>	Middle <b>Edward</b>	Last <b>Cummings</b>				
4. DATE OF DEATH <b>Dec. 19,</b>	Month <b>1956</b>	Day <b>Day</b>	Year <b>Year</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/22/91</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired U. S. Navy</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>New Orleans, La.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Edward Cummings</b>		14. MOTHER'S MAIDEN NAME <b>Unk</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1911 - 1932</b>	17. INFORMANT <b>Naval Discharge Papers</b>				
Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> INTERVAL BETWEEN ONSET AND DEATH ?							
DUE TO <b>420.1</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		DATE SIGNED <b>Dec. 22, 1956</b>					
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/24/56</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping &amp; Kirkley</i>		ADDRESS <b>Glen Burnie, Md.</b>					
		24a. REC'D BY REGISTRAR <b>DEC 26 1956</b>	24b. REGISTRAR'S SIGNATURE <i>L. G. Ball</i>				

BUREAU V. S.

DEC 28 1956

**REGELIVE**

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12031

24

CERTIFICATE OF DEATH  
12066

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	ANNE ARUNDEL MARYLAND FERNDALE	STATE CITY (If outside corporate limits, write RURAL and give nearest town) TOWN	Maryland COUNTY Anne Arundel Ferndale (Glen Burnie P.O.)
HOSPITAL OR INSTITUTION OR STREET ADDRESS  8 FERNDALE Road.		STREET ADDRESS  8 Ferndale Road	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> DECEMBER 4 1956	
5. SEX Female	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Feb. 24, 1872
9. AGE last birthday 84 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework (ret.)	11. KIND OF BUSINESS OR INDUSTRY own home	12. CITIZEN OF WHAT COUNTRY U.S.A
13. FATHER'S NAME William Watts	14. MOTHER'S MAIDEN NAME Mary C. Tzagare		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No	16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Edwin DaVault Ferndale Md
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
332X IMMEDIATE CAUSE (A) Cerebral Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 4 days	
ANTECEDENT CAUSE(S) DUE TO Cysticercosis, general			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> none			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21a. INJURY OCCURRED M. at work	21i. HOW DID INJURY OCCUR?	
Whila Not while at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from 12/2, 1956, to 12/4, 1956, that I last saw the deceased alive on 12/4, 1956, and that death occurred at 11:45P.M., from the causes and on the date stated above.			
SIGNATURE Bobby L. Jones		ADDRESS (Street, city, town, state) M.D. 104 Corrin Henry S. Glen Burnie 12/5/56	
DATE SIGNED 12/5/56		DATE SIGNED 12/5/56	
23. BURIAL, CREMATION, REMOVAL (SPECIMEN) Burial	DATE THEREOF Dec. 8, 1956	NAME OF CEMETERY OR CREMATORIY Loudon Park	LOCATION (City, town, or county) Baltimore, Md.
24. REC'D. BY REGISTRAR DATE DEC 6 1956	REGISTRAR'S SIGNATURE L.J. DeLaney	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS T. Washington, Glen Burnie, Md.	

BY THE STATE DEPARTMENT OF NEVADA - KELLOGG

CERTIFICATE OF DEATH

DECEMBER 6, 1956

BUREAU V.

DEC 6 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12032

## 12067 CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>3½ months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		d. STREET ADDRESS <b>2401 Lourette Av.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Edna</b>	Middle <b>Finny</b>	Last <b>Deer</b>	4. DATE OF DEATH <b>Dec. 21, 1906</b>	Month <b>12</b>	Day <b>2</b>	Year <b>1956</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 21, 1906</b>	9. AGE (In years months days) <b>50 yrs.</b>	10. IF UNDER 1 YEAR Months <b>50</b>	11. IF UNDER 24 HRS. Hours <b>50</b>	12. IF UNDER 24 HRS. Min. <b>50</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>Katie Finny</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Crownsville State Hospital, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO Hypertensive Cardiovascular Disease (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> 3½ mo.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ 19 _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/15/56</b> , 19_____, to <b>12/2/56</b> , 19_____, that I last saw the deceased alive on <b>12/2/56</b> , 19_____, and that death occurred at <b>3:30 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>12/2/56</b>							
ACTUAL SIGNATURE <i>Ludwig Benedict</i>		M.D.					
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M.D.</b>		Crownsville, Md.		12/2/56			
22a. BURIAL, CREMATION, REMOVAL (specify) <b>12/5/56</b>		22b. DATE THEREOF <b>12/5/56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Auburn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Geo M. Kelson</i>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>12/4/56</b>	
						24b. REGISTRAR'S SIGNATURE <i>R. M. Joyce</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

## WISCONSIN STATE DEPARTMENT OF HEALTH - BALTIMORE 38

## CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
DECEMBER 5, 1965				
FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE				
BUREAU V. S.				
RECEIVED				

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C L-55 10/M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12033

## CERTIFICATE OF DEATH

12039

Reg. Dist. No. 21

## 1. PLACE OF DEATH

COUNTY

Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN

LENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Dinneraphis

NAME OF  
DECEASED  
(Type or Print)

ADELLE E. DENSMORE

S. SEX

6. COLOR OR  
RACE

female

white

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

At Home

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

widowed

8. DATE OF BIRTH

8/17/1870

9. AGE last birthday

86

yrs.

Months

Days

Hours

Min.

4. DATE  
OF  
DEATH

DEC. 9

1956

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY

Carroll

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Woodbine

(If rural give location)

STREET  
ADDRESS

13. FATHER'S NAME

William G. Kempton

4. DATE  
OF  
DEATH

DEC. 9

1956

10b. KIND OF BUSINESS  
OR INDUSTRY

Minneapolis, Minn.

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

14. MOTHER'S MAIDEN NAME

Jeanette Rosette Fox

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Mrs. Ruth D. McNally-  
Rt. 2 - Woodbine P.O. - MarylandINTERVAL BETWEEN  
ONSET AND DEATH

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

427.1 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

Arthritis clavicle Condritis Varicose Veins yrs.  
Condritis Tonitis 3 wks.II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

21f. HOW DID INJURY OCCUR?

M. While at work  Not while at work 

22. I hereby certify that I attended the deceased from 9/11/12, 1956, to DEC 9, 1956, that I last saw the deceased alive on DEC 7, 1956, and that death occurred at 7:57 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

Removal

DATE THEREOF

12/11/56

NAME OF CEMETERY OR CREMATORI

Lakewood Cemetery

LOCATION (City, town, or county)

Minneapolis, Minn.

24. REC'D BY REGISTRAR

DATE DEC 12 1956

REGISTRAR'S SIGNATURE

John J. French

25. FUNERAL DIRECTOR'S SIGNATURE

The S.H. Hines Co. 2901 14th St. N.W.  
Washington 9, D.C.

WISCONSIN STATE GOVERNMENT OF THE UNITED STATES

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 18 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12034

## 12040 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTRY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville, Md.</b>		d. STREET ADDRESS <b>6113 42nd Place</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Emergency Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Rosabel</b>	Middle	Last <b>De Vane</b>	4. DATE OF DEATH <b>DEC 31</b>	Month	Day	Year <b>1956</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>May 24, 1881</b>	9. AGE (In years lost <b>75</b> birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Maultsy</b>			14. MOTHER'S MAIDEN NAME <b>Eliza King</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>R. K. De Vane</b>		Address <b>Hyattsville, Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>420.0</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Atherosclerotic Heart Disease</b> DUE TO <b>171</b> (c) <b>Hypertension</b> DUE TO <b>171</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-1-</b> , 19 <b>56</b> to <b>12-31-1956</b> that I last saw the deceased alive on <b>12-31-1956</b> , and that death occurred at <b>1230 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Shaw St.</b> DATE SIGNED <b>12/31/56</b>							
ACTUAL SIGNATURE <b>James R. Martin</b> PHYSICIAN'S NAME (Type) <b>JAMES R. MARTIN</b> ANNAPOLIS, MD.							
22a. BURIAL, CREMATION, BURIETAL (Specify)	22b. DATE THEREOF <b>1/2/57</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Carver Creek Cemetery</b>		22d. LOCATION (City, town, or county) <b>Council</b> (State) <b>North Carolina</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons</b> ADDRESS <b>Hyattsville, Md</b>				24a. REC'D BY REGISTRAR <b>JAN 5 1957</b>	24b. REGISTRAR'S SIGNATURE <b>John L. French</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

A photograph of two rectangular stamps. The top stamp has the word 'BUREAU' at the top, followed by 'V.' in the middle, and 'S.' at the bottom. The bottom stamp has the letters 'REGELIV' on the left and 'ED' on the right, separated by a vertical line.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12035

Item 20 Film 209 1-16-57 ams

12068

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Anne Arundel</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade, Md.</u>		c. LENGTH OF STAY IN 1b <u>Post Stockade FGGM</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft George G Meade, Md</u>		d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Post Stockade FGGM</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>VERNON</u>		First <u>L.</u>	Middle <u>DILLARD</u>	Last	4. DATE OF DEATH <u>December 30, 1956</u>	Month <u>December</u>	Day <u>30</u>	Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Neg</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH <u>Feb. 19, 1931</u>	9. AGE (In years lost birthday) <u>25</u> yrs.	IF UNDER 1 YEAR <u>Months</u>	IF UNDER 24 HRS. <u>Days</u>	Hours <u>00</u>	Min. <u>00</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Soldier</u>		11. BIRTHPLACE (State or foreign country) <u>Pittsburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>					
13. FATHER'S NAME <u>Archie Dillard</u>		14. MOTHER'S MAIDEN NAME <u>Mattie Buchanan</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Personnel Records</u>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>919.8</u>		DUE TO <u>Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.</u>		Bullet Wound of thorax with rupture of aorta		INTERVAL BETWEEN ONSET AND DEATH					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? <u>NO</u> <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>The prisoner was shot trying to escape from the post stockade</u>									
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>0900</u> p. m. <u>1956</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>POST STOCKADE</u>		20f. (City or town) <u>Fort George G. Meade, Md.</u>		(County) <u></u>		(State) <u></u>	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 0930 A.M. from the causes and on the date stated above.		ACCIDENT		ADDRESS (Street, city or town, state) <u>2101-1 USAH Ft Meade, Md</u>		DATE SIGNED <u>30 Dec 56</u>					
ACTUAL SIGNATURE <u>John G. Robertson CAPT MC</u>		PHYSICIAN'S NAME (Type) <u>JOHN G. ROBERTSON, CAPT, MC</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Releas Phillips</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Phillips</u>		22d. LOCATION (City, town, or county) <u>Pittsburg Pa.</u>		(State) <u></u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arlington S. Phillips, 1808 N. Monroe St.</u>		ADDRESS <u>Baltimore, Md</u>		24a. REC'D BY REGISTRAR <u>31 Dec 56</u>		24b. REGISTRAR'S SIGNATURE <u>W.L. Saylor</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. S.

JAN 3 1957

RECEIVED

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

12036, b  
st. No. 52

# **CERTIFICATE OF DEATH**

12069

**Reg. Dist. No**

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>aa</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>aa</i>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)		(If rural give location)	
TOWN <i>Friendship</i>		<i>6 yrs</i>		TOWN <i>Friendship</i>		<i>Md</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)		(First) <i>Jeannette</i> (Middle) <i>W.</i> (Last) <i>Dorsey</i>		4. DATE OF DEATH <i>12 8 56</i>		(Month) <i>12</i> (Day) <i>8</i> (Year) <i>56</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>June 4 1889</i>	9. AGE last birthday <i>67 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas B. Hood</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Rachel Ann Hutchins</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mr. Thomas H. Dorsey, Friendship</i>		18. MEDICAL CERTIFICATION <i>Infant of left lung</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  465X IMMEDIATE CAUSE (A) _____ ANTECEDENT CAUSE(S) DUE TO _____ DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE _____ STATING UNDERLYING CAUSE LAST, DUE TO _____ (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) <i>Omory</i>		(County) <i>Friendship</i> (State) <i>MD</i>	
21d. TIME OF INJURY (Month) <i>12</i> (Day) <i>8</i> (Year) <i>56</i> (Hour) <i>6 A.M.</i>		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>12/13 1956</i> , to <i>12/8 56</i> , that I last saw the deceased alive on <i>12/17 1956</i> , and that death occurred at <i>6 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>W. Ward</i> ADDRESS (Street, city, town, state) <i>Omory</i> DATE SIGNED <i>12/8/56</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>12/10/56</i>		NAME OF CEMETERY OR CREMATORIAL <i>Friendship</i>		LOCATION (City, town, or county) <i>Friendship Md.</i> (State)	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Grace L. Hutchins</i>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <i>Friendship Md.</i>	
DATE <i>12/8/56</i>							

U.S. GOVERNMENT PRINTING OFFICE: 1956 10-1400

CERTIFICATE OF DEATH

DEATH CERTIFICATE

RECEIVED BY THE

DEPARTMENT OF

THE UNITED STATES

OF LABOR

FOR THE

YEAR

1956

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BUREAU Y.

EC 17 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12041

## CERTIFICATE OF DEATH

12037  
Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		d. STREET ADDRESS <b>St Stephens Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>St Stephens Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ESTHER</b>	Middle <b>N</b>	Last <b>DRAPER</b>	4. DATE OF DEATH	Month <b>DECEMBER</b>	Day <b>5</b>	Year <b>19 56</b>		
5. SEX	6. COLOR OR RACE <b>Female</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1912</b>	9. AGE (In years last birthday) <b>44 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	11. BIRTHPLACE (State or foreign country) <b>West, Va</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. (If yes, give sex or dates of service) <b>none</b>	17. INFORMANT <b>Mr. Raymond L. Braper - Husband - same as # 2</b>	Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>genl. carcinomatosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>171X</b> (b) <b>Ca of cervix</b>									
DUE TO <b>Ca of cervix</b>									
DUE TO <b>Ca of cervix</b>									
DUE TO <b>Ca of cervix</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>11</b>	Day <b>19</b>	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Glen Burnie</b>	(County) <b>Maryland</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>April 25, 1955</b> , to <b>Dec. 5, 1956</b> , that I last saw the deceased alive on <b>Dec. 5, 1956</b> , and that death occurred at <b>7:05 P.M.</b> from the causes and on the date stated above.			ADDRESS (Street, city or town, state) <b>Amos Garrett Blvd., Annapolis, Md.</b>						
ACTUAL SIGNATURE <b>S. Borsuck</b>			DATE SIGNED <b>12/7/56</b>						
PHYSICIAN'S NAME (Type) <b>S. Borsuck</b>		MD		Amos Garrett Blvd., Annapolis, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-9-56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Glen Burnie</b>		(State) <b>Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>ANNAPOLIS, Md.</b>		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <b>Brunch</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12038

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		12070		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)					
		MARYLAND		a. STATE	b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
Riviera Beach		16		Baltimore Rio Beach					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
Bay & Harbor Rd.		3971 Harlem Rd.							
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month Day Year				
	HENRY		DURNER	DEC 19	1956				
S. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost/birthday) yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
m	w		9-23-69	77					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)					
Retail Salesman		G.S.R.		Md.					
12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
Samuel		Mary Watts							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT					
No				Family Same					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE INTERVAL BETWEEN ONSET AND DEATH 5 YEARS									
422.1 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the under- } (b) lying cause lost. } DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from FEB 1956 to DEC 19 1956, that I last saw the deceased alive on DEC 19 1956, and that death occurred at 10:30P M, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		J. Brady Smith M.D.		RIVIERA BEACH, MD		DATE SIGNED 12/20/56			
PHYSICIAN'S NAME (Type)		J. BRADY SMITH							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)			
17-22-56		17-22-56		BETH HAVEN		BETH HAVEN			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE			
McCoy Funeral Home						S. D. Allen			
				DEC 26 1956					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12071 CERTIFICATE OF DEATH

Reg. Dist. No.

12039

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Same</b>		b. COUNTY <b>Same</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN 1b <b>1 Month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harundale</b> <b>1336 Howard Rd. 8766/67/68/69</b>		d. STREET ADDRESS <b>Same</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Aida Marie Eakin</b>		First	Middle	Last	4. DATE OF DEATH <b>December 17th.</b>	Month	Day	Year
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5/8/89</b>	9. AGE (In years lost birthday) <b>67 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hospital Clerk (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Drug store</b>		11. BIRTHPLACE (State or foreign country) <b>Industry, Pennsylvania.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Olive E. Aber</b>		14. MOTHER'S MAIDEN NAME <b>Lydia Walton</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>No 202-28-4492</b>		17. INFORMANT <b>Mrs. Blanche E. McCormick (Daughter).</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>156.1</b>		DUE TO <b>Carcinoma of Liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 months.</b>				
Conditions, if any, which gave rise to immediate cause (o), stating the under-lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>12/2/56</b> , 19, to <b>12/17/56</b> , 19, that I last saw the deceased alive on <b>12/15/56</b> , 19, and that death occurred at <b>3 P. M.</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <b>12/17/56</b>		
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>				M.D. <b>Glen Burnie, Md.</b>				
PHYSICIAN'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 20/56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Beaver Cemetery</b>		22d. LOCATION (City, town, or county) <b>Beaver</b>		(State) <b>Beaver Co., Pa.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard L. Springer</b>		ADDRESS <b>Glen Burnie, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 19 1956</b>		24b. REGISTRAR'S SIGNATURE <b>L. J. Kelly</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

41, BROMELIA-THYMUS - MUSCUM TRICOSTATUM

BUREAU V. S.

DEC 20 1956

REGELIV ED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12042 CERTIFICATE OF DEATH

12040

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>H. A. CO</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>8 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural. 1</i>	
3. NAME OF DECEASED (Type or print) <i>Everett Ellsworth</i>		d. STREET ADDRESS <i>628 Bay Ridge Ave</i>	
4. SEX <i>M</i>	5. COLOR OR RACE <i>W</i>	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>Jan. 11, 1901</i>
8. DATE OF DEATH <i>12</i>	9. MONTH <i>Jan.</i>	10. DAY <i>27</i>	11. YEAR <i>1956</i>
12. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Business</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME —		14. MOTHER'S MAIDEN NAME —	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. —	
17. INFORMANT <i>Ethel May Edelen</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Esophagitis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Melastasis</i> DUE TO (c) <i>—</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec</i> , 19 <i>55</i> , to <i>Dec</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>12/27/56</i> , 19 <i>56</i> , and that death occurred at <i>7 M.</i> from the causes and on the date stated above. ADDRESS (Street, city, or town, state) <i>Annapolis, Maryland</i> DATE SIGNED <i>12/27/56</i>			
ACTUAL SIGNATURE <i>E. Linhardt</i>		M.D. <i>Annapolis, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>E. Linhardt</i>		Annapolis - MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12/30/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Trinity Cemetery</i>
22d. LOCATION (City, town, or county) <i>Upper Marlboro</i>		(State) <i>Id.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ritchie Bros., Upper Marlboro, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>DEC 27 1956</i>	24b. REGISTRAR'S SIGNATURE <i>J. M. French</i>

## 15013 CERTIFICATE OF DEATH

BUREAU V. S.

DEC 31 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12041 *24*

Reg. Dist. No.

**12072**

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>A.A.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>		c. LENGTH OF STAY IN 1b <b>Few seconds</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Orchard Beach, P.O. Baltimore 26</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Reese Rd. State Rd. # 554</b>		d. STREET ADDRESS <b>Fernhill Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Edward EDWARD HEALY ERISMAN</b>		First	Middle	Last	4. DATE OF DEATH <b>12/9/56</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>12/25/23</b>	9. AGE (in years last birthday) <b>32 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saf Employed Taverns and Grills</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Edward Hugh Erisman</b>		14. MOTHER'S MAIDEN NAME <b>Anna Healey</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>World War No. II</b>		17. INFORMANT <b>Mrs. Emily E. Erisman -Fernhill Rd., Orchard Beach</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<b>Fracture of skull</b>						
825X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO <b>b)</b>								
DUE TO <b>c)</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident (no eye witness)</b>						
20c. TIME OF INJURY Hour <b>1/15 A.M.</b>		Month, Day, Year <b>12/9/56 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 554</b>	20f. (City or town) <b>Severn</b>	(County) <b>A.A.</b>	(State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>		DATE SIGNED <b>12/9/56</b>						
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/12/56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cem</b>		22d. LOCATION (City, town, or county) <b>Catonsville, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Schuler &amp; Sons - Balt. 17 Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR <b>Dec. 10, 1956</b>		24b. REGISTRAR'S SIGNATURE <i>L.J. DeAlba</i>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

UNIVERSITY OF CALIFORNIA - SAN FRANCISCO  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 11 1956

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12073 CERTIFICATE OF DEATH

12042  
25

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>AA</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>50 Brooklyn</b>		c. LENGTH OF STAY IN 1b <b>Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brooklyn</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1609 Church Street</b>				d. STREET ADDRESS <b>1609 Church St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>First John</b>		Middle		Last <b>Esterka</b>		4. DATE OF DEATH <b>12</b>	Month	Day	Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>11/22/83</b>		9. AGE (In years lost birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>EUROPE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <b>No</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Family</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 coronary occlusion</b>							INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO</b>			(b) <b>hypertension cardiac vascular disease</b>						
			(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____			June 1956, to Dec 14, 1956		that I last saw the deceased				
					ADDRESS (Street, city or town, state)				
ACTUAL SIGNATURE <b>Philip W. Keister</b>			M.D.		DATE SIGNED <b>302 Patapsco Ave</b>				
PHYSICIAN'S NAME (Type) <b>PHILIP W. KEISTER</b>					<b>Baltimore 25 Md.</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/17/56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Cedar Hill Cem</b>		22d. LOCATION (City, town, or county) <b>Brooklyn, Md.</b>			(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home</b>		ADDRESS <b>130 E. Fort Ave. #30</b>		24a. REC'D BY REGISTRAR <b>DEC 17 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Ma. Thompson</b>			

## WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION 18

## CERTIFICATE OF DEATH

Name of deceased		Date of birth		Cause of death	
John Doe		1900-01-01		Diseased	
Age at time of death		Length of marriage		Name of physician	
50 years		10 years		Dr. John Doe	
Occupation		Place of residence		Name of hospital	
Laborer		Milwaukee		Milwaukee General Hospital	
Residence at time of death		Time of death		Name of coroner	
Milwaukee		12:00 PM		John Doe	
Relationship to deceased		Signature		Date	
Son		John Doe		1956	
Signature of physician		Signature of coroner		Signature of state health officer	
John Doe		John Doe		John Doe	
Date of report		Date of issue		Signature of state health officer	
Dec 17 1956		Dec 17 1956		John Doe	

FBI

DEC 17 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12043

12074

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>lyr.3mos.21days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		3401-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>1005 Tiffany Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>W.</b>	Last <b>Galloway</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>24</b>	Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/25/85.</b>	9. AGE (In years 'bst. birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None listed</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>James Galloway</b>		14. MOTHER'S MAIDEN NAME <b>Priscilla Galloway</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Crownsville State Hospital Crownsville, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Internal Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) <b>Ruptured Aneurism of the Aorta</b> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Senility and Syphilis</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Crownsville, Md.</b>	(County) <b>Crownsville</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>12/20</b> , 19 <b>56</b> , to <b>12/24</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12/21</b> , 19 <b>56</b> , and that death occurred at <b>4:00a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>12/24/56</b>								
ACTUAL SIGNATURE <i>Lionel M. Mann, M.D.</i>	PHYSICIAN'S NAME (Type) <b>Lionel M. Mann, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>12/27/56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Auburn</b>	22d. LOCATION (City, town, or county) <b>Baltimore City, Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Lauer</i>		ADDRESS <i>802 Madison Ave</i>	24a. REC'D BY REGISTRAR <b>DEC 28 1956</b>	24b. REGISTRAR'S SIGNATURE <i>38 M. J. G.</i>				

## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

LAW OFFICES OF

STATE OF MARYLAND  
DEPARTMENT OF

HEALTH

BALTIMORE

18

MD

12043

12044

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....

## 1. PLACE OF DEATH:

COUNTY A.H.CO.

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)  
TOWNLENGTH OF STAY  
(in this place)HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Anne Arundel General

3. NAME OF  
DECEASED:  
(Type or Print)

(First)

(Middle)

(Last)

Pidgeon

4. SEX:  
M.6. COLOR OR  
RACE: W7. SINGLE, MARRIED,  
WIDOWED, DIVORCED.  
(Specify): M.8. DATE OF BIRTH:  
Sept. 28 1902

9. AGE last birthday:

57

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of  
work done during most of work life,  
even if retired): Contractor10b. KIND OF BUSINESS OR  
INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT  
COUNTRY? U.S.

## 13. FATHER'S NAME:

Joseph Golebiewski

## 14. MOTHER'S MAIDEN NAME:

Tillie Krzykawski

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unk.) (If Yes, give war or dates of  
service)

No

16. SOCIAL SECURITY NO.:

## 17. INFORMANT &amp; ADDRESS:

Mary Waglewicz Golebiewski (same)

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
Immediate cause

(a) DUE TO

CORONARY DISEASE.

INTERVAL BETWEEN  
ONSET AND DEATH

Sudden.

## Antecedent cause(s)

Diseases or conditions, if any, (b)  
giving rise to the above cause DUE TO  
stating underlying cause last (c)II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes  No 21a. EXTERNAL CAUSE WAS  
PRIMARY  OR CONTRIBUTING   
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,  
OF street, office bldg., etc.,  
INJURY)

21c. (City or town) (County)

(State)

21d. TIME (Month) (Day) (Year) (Hour)  
OF INJURY M.21e. INJURY OCCURRED  
While at work  Not while  
at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes  , Accident  , Suicide  , Homicide  , Undetermined cause  .

SIGNATURE

E. Lee Hudd

CHIEF MEDICAL EXAMINER  
DEPUTY MEDICAL EXAMINER  
M. D. ASSISTANT MEDICAL EXAM.

DATE SIGNED

12-20-56

23. BURIAL, CREMATION,  
REMOVAL (Specify): Burial

DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)

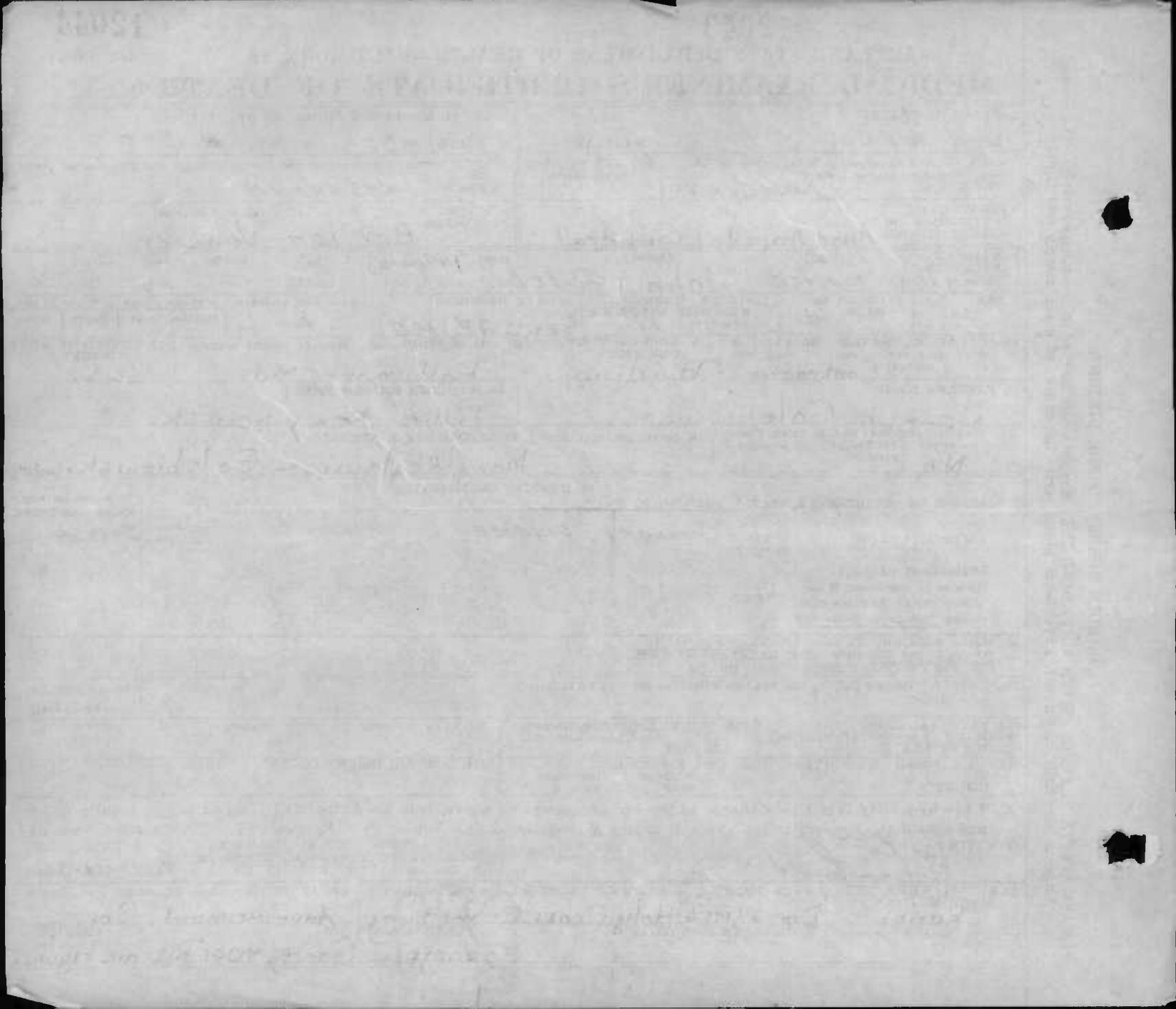
DATE REC'D BY LOCAL  
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

George J. Gance, 4001 Ritchie Hwy.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12045

12075

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH o. COUNTY		Anne Arundal MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b ? Rural - Baltimore		a. STATE Maryland b. COUNTY Anne Arundal c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7416 Fort Smallwood Road		e. STREET ADDRESS 7416 Fort Smallwood Road		d. STREET ADDRESS 7416 Fort Smallwood Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katherine Grabowski		First	Middle	Last	4. DATE OF DEATH Dec. 30, 1956
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 18, 1875	9. AGE (In years lost birthday) 81 yrs.	Month Day Year
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Michael Jerzak		14. MOTHER'S MAIDEN NAME Katherine ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. None		17. INFORMANT Frank Grabowski-7416 Fort Smallwood Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) (c)		Coronary Thrombosis INTERVAL BETWEEN ONSET AND DEATH 6 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arthritis		3 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JUNE, 1956, to DEC 30, 1956, that I last saw the deceased alive on 12/29, 1956, and that death occurred at 2:10 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE J. Brady Smith PHYSICIAN'S NAME (Type) J. BRADY SMITH		ADDRESS (Street, city or town, state) Riviera Beach, Md. DATE SIGNED 12/31/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/57		22c. NAME OF CEMETERY OR CREMATORIAL St. Stanislaus Cemetery Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Moran-3000 E.Baltimore St.		ADDRESS JAN 2 1957		24d. REC'D BY REGISTRAR 24d. REGISTRAR'S SIGNATURE John A. Moran	

CERTIFICATE OF DRAFT

J

JAN 2 19

FEDERAL BUREAU OF INVESTIGATION  
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12076

## CERTIFICATE OF DEATH

12046

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>7 yrs. 5 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Alberta</b>	Middle <b>Gray</b>	Last Month Day Year <b>12 31 19 56</b>
4. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/11</b>
9. AGE (In years last birthday) <b>45</b>	10. IF UNDER 1 YEAR Months <b>-</b> Days <b>-</b>	11. IF UNDER 24 HRS. Hours <b>-</b> Min. <b>-</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Clint Mitchell</b>		14. MOTHER'S MAIDEN NAME <b>Anna (Last name not given)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>	16. SOCIAL SECURITY NO. <b>Unk.</b>	17. INFORMANT <b>Hospital Records</b>	Address <b>Crownsville State Hospital Crownsville, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Dehydration and Malnutrition with Hypostatic Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>General Paresis of the Insane</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Epilepsy, Hypertensive Cardiovascular Disease &amp; Decubitus ulcers</b>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Crownsville</b>	(County) <b>Md.</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>7/10</b> , 19 <b>56</b> , to <b>12/31</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12/28</b> , 19 <b>56</b> , and that death occurred at <b>3:00a.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>			
ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>	DATE SIGNED <b>12/31/56</b>		
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>			
22a. BURIAL, Cremation or Scattering (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-5-1957</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Mt. Auburn</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sarah L. Brown &amp; Son</i>	ADDRESS <b>108 W. MONTGOMERY ST</b>	24a. REC'D BY REGISTRAR <b>12/31/56</b>	24b. REGISTRAR'S SIGNATURE <i>John J. Kelly</i>

SURREAU V. S.

IAN 3 1957

REGELYÉD

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13102

28

12077

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>31 yrs. 3 mos. 1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		3101-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>1135 Stockton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <b>Georgia</b>	Middle	Last <b>Gross</b>	4. DATE OF DEATH <b>Not listed</b>	Month <b>12</b>	Day <b>26</b>	Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Not listed</b>	9. AGE (In years last birthday) <b>72?</b> yrs.	IF UNDER 1 YEAR Months <b>-</b>	IF UNDER 24 HRS. Days <b>-</b>	Hours <b>-</b>	Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ink.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Not listed</b>			14. MOTHER'S MAIDEN NAME <b>Not listed</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hospital Crownsville, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>443-X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Renal Failure</b> DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive Cardiovascular Disease, Hypostatic Pneumonia, Senility</b>								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Crownsville</b>		(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>12/5</b> , 19 <b>56</b> , to <b>12/26</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12/26</b> , 19 <b>56</b> , and that death occurred at <b>9:45 a.m.</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>								
DATE SIGNED <b>12/26/56</b>								
ACTUAL SIGNATURE <b>Lionel McHenry Mapp.</b>								
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1-4-56</b>		22c. NAME OF CEMETERY OR CREATORY <b>University of Md.</b>		22d. LOCATION (City, town, or county) <b>Baltimore Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Annapolis, Md.</b>		ADDRESS <b>101 1957</b>		24a. REC'D BY REGISTRAR <b>J. M. Joyce</b>		24b. REGISTRAR'S SIGNATURE		

WISCONSIN STATE DEPARTMENT OF HEALTH - BIRTHING

CERTIFICATE OF DEATH

DEATH

REGISTRATION

NUMBER

NAME

SEX

AGE

CAUSE

TIME

PLACE

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RECEIVED  
BUREAU V. S.

JAN 10 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 18&amp;20 Film G208 12-28-56 a.m.

12047

12078

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X GREENOCK</i>		c. LENGTH OF STAY IN 1b <i>3 MO</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>o</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Greenock</i>			
3. NAME OF DECEASED (Type or print) <i>WARREN RODNEY Gross</i>		First <i>W</i>	Middle <i>R</i>		
4. DATE OF DEATH <i>DEC. 5 1956</i>	Month <i>DEC.</i>	Day <i>5</i>	Year <i>1956</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>6/5/55</i>		
8. AGE (In years last birthday) <i>18 mo.</i>	9. IF UNDER 1 YEAR Months <i>6</i>	10. IF UNDER 24 HRS. Days <i>0</i>	11. Hours <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>o</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>o</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>o</i>		
13. FATHER'S NAME <i>ALBERT Gross</i>	14. MOTHER'S MAIDEN NAME <i>Blondell Chapman Gross</i>	Address <i>Blondell Gross, Tracy's Md</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>o</i>	16. SOCIAL SECURITY NO. <i>o</i>	17. INFORMANT <i>o</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>916.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>o</i>		
		(b) <i>Burns -</i> DUE TO Stove exploded setting house afire and house burn to the ground - child left accidentally in house			
		(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>o</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>House burn to ground and child accidentally left in house</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 5 p. m. <i>12/5/56 19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	20f. (City or town) <i>Lothian P.O.</i>	(County) <i>A.A.</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>not at all</i> , 19 <i>o</i> , to <i>o</i> , 19 <i>o</i> , that I last saw the deceased alive on <i>not at all</i> , 19 <i>o</i> , and that death occurred at <i>S.P. M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Emily H. Wilson</i> PHYSICIAN'S NAME (Type) <i>acting corner</i>	ADDRESS (Street, city or town, state) <i>Lothian Md.</i>		DATE SIGNED <i>12-5-56</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/7/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Adams Chapel</i>	22d. LOCATION (City, town, or county) <i>Lothian</i>	(State) <i>1956</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rebecca Hardisty Salterville Md</i>	ADDRESS <i>o</i>	24a. REC'D BY REGISTRAR <i>J. French</i>	24b. REGISTRAR'S SIGNATURE <i>J. French</i>	DATE <i>18</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
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BUREAU V. S.

DEC 1956

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12048

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE		Maryland Anne Arundel				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reverell Station, Md.</i>		d. STREET ADDRESS				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.C. General Hospital</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>JOHN</i>	Middle <i>YEWELL</i>	Last <i>HALL</i>	4. DATE OF DEATH	Month <i>DEC</i>	Day <i>13</i>	Year <i>1956</i>		
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Oct 10 1902</i>	9. AGE (In years last birthday) <i>54</i> yrs.	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>John Y. Hall</i>		14. MOTHER'S MAIDEN NAME <i>Lattie V. Van Pelt</i>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes WW II</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Gertrude Frantome</i>		Address <i>149 Pitt St Annapolis Md</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>443X</i>		DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. <i></i>		Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>				
(b) DUE TO <i></i>		(c) <i>Hypertensive Cardio-Vascular Disease</i>						1 day		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>12/12/56</i> , to <i>12/13/56</i> , that I last saw the deceased alive on <i>12-13- 1956</i> , and that death occurred at <i>Md.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>James R. Martin</i>		ADDRESS (Street, city or town, state) <i>Annapolis, Md</i>								
PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>		DATE SIGNED <i>12/13/56</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-12-56</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>U.S. National Cem.</i>		22d. LOCATION (City, town, or county) <i>Annapolis Maryland</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Son Annapolis Md</i>		ADDRESS <i>John W. Taylor Son Annapolis Md</i>								
		24a. REC'D BY REGISTRAR <i>John W. Taylor</i>								
		24b. REGISTRAR'S SIGNATURE <i>John W. Taylor</i>								

WIREGRAMS - THE DEPARTMENT OF HEDWIG-BALTIMORE IS

CERTIFICATE OF DEATH

DEATH

DEATH TO

DEATH FROM

DEATH BY

DEATH IN

DEATH ON

DEATH AT

BUREAU X-8

DEC 21 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12049

12079

## CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>9mos. 16days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		d. STREET ADDRESS <b>242 N. Spring Court</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Maude</b>		First	Middle	Last	4. DATE OF DEATH <b>Haney</b>	Month	Day	Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1893? 1899? 57? 69? yrs.</b>	9. AGE (In years (at birthday)	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Not given</b>		14. MOTHER'S MAIDEN NAME <b>Mahala Brown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hospital Crownsville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Coma</b> <i>260X</i>		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Intestinal Obstruction</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Intestinal Obstruction</b>							
20c. TIME OF INJURY Hour a. p. p. m.		Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>7/9</b> , 19 <b>56</b> , to <b>12/7</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12/7</b> , 19 <b>56</b> , and that death occurred at <b>4:20 P.M.</b> from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>	
ACTUAL SIGNATURE <i>Lionel McHenry Mapp.</i>		DATE SIGNED <b>12/7/56</b>							
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-11-56</b>		22b. DATE THEREOF <b>12-11-56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Burial</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lionel McHenry Mapp</i>		ADDRESS <b>802</b>		24a. REC'D BY REGISTRAR DATE <b>12/10/56</b>		24b. REGISTRAR'S SIGNATURE <i>L. M. Joyce</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

## CALIFORNIA STATE DEPARTMENT OF HEALTH - DIVISION 18

## CERTIFICATE OF DEATH

NO. 51

1956

Name:

Date of death:

Place:

T.C.

V.A.P.

BUREAU V. S.

DEC 11 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13103  
21

12045

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
<i>Anne Arundel MARYLAND</i>		b. COUNTY <i>Maryland Anne Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne General Hosp.</i>		d. STREET ADDRESS <i>Tracey Landing</i>	
3. NAME OF DECEASED (Type or print)		First <i>Frank</i>	Middle <i></i>
4. DATE OF DEATH		Last <i>Hopkins</i>	Month <i>12</i>
			Day <i>27</i>
			Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>4-29-1904</i>
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Butcher</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>E. Taylor Chewing</i>	
10c. FATHER'S NAME <i>P.</i>		11. BIRTHPLACE (State or foreign country) <i>Liverpool, England</i>	
13. MOTHER'S MAIDEN NAME <i>P.</i>		14. MOTHER'S MAIDEN NAME <i>Annie Hopkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Annie Hopkins - Tracey Landing, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>381X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), slotting the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>central hemorrhage</i> <i>hypertension.</i> <i>atherosclerosis.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Dec. 26, 1956</i> (County) <i>Anne Arundel</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Dec. 24, 1956</i> , to <i>Dec. 26, 1956</i> , that I last saw the deceased alive on <i>Dec. 26, 1956</i> , and that death occurred at <i>6 P. M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Tolson, Md.</i>	
ACTUAL SIGNATURE <i>Erin H. Weber</i>		DATE SIGNED <i>12-27-56</i>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>12-31-56</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) <i>Annapolis, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II - Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>1-1058</i> 24b. REGISTRAR'S SIGNATURE <i>Tom J. French</i>	
VS A15 (4) 15M 9/55		DATE	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12051**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 77

1  
 TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File-pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>AIRNE - ARUNDEL MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>SAME</b> b. COUNTY <b>SAME</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL give nearest town) <b>LAUREL</b>		c. LENGTH OF STAY IN lb <b>all-life</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ROUTE-T - Box-174A.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>KENNETH - BERNARD - JONES,</b>		First	Middle
4. DATE OF DEATH <b>DECEMBER 24 1956</b>		Last	Month Day Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/15/06</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PRINCE GEORGE HOSPITAL</b>	
11. BIRTHPLACE (State or foreign country) <b>PRINCE GEORGE COUNTY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JESSE - JONES.</b>		14. MOTHER'S MAIDEN NAME <b>WILLIE - MAE - SUE ST.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>None</b> 17. INFORMANT <b>WILLIE - MAE - JONES - (MOTHER)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a), <b>SUFFOCATION</b> 9240 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>50 MIN.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>BABY SLEPT BETWEEN MOTHER AND ANOTHER CHILD</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>9 o.m.</b> 12/24 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b> 20f. (City or town) <b>LAUREL - A.A.</b> (County) <b>Md.</b> (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Gustave H. Faubert, M.D.</b>		DATE SIGNED <b>12/24/56</b>	
EXAMINER'S NAME (Type) <b>GUSTAVE H. FAUBERT, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremated</b>		22b. DATE THEREOF <b>12-26-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>DAN'l Bonn Branch</b> 22d. LOCATION (City, town, or county) <b>Towson, Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Smith</b>		ADDRESS <b>1820-9 St NW</b>	24a. REC'D BY REGISTRAR <b>DEC 27 1956</b> 24b. REGISTRAR'S SIGNATURE <b>Clara Basiley</b>

MANUFACTURED IN THE STATE OF HAWAII - VALUATION - 18

VEHICULAR EXAMINER'S CERTIFICATE OF DEATH

1952

KUREAU Y. S.

DEC 27 1952

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12046 CERTIFICATE OF DEATH

Reg. Dist. No.

12052  
21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				b. COUNTY <i>A.A.</i>			
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Anne Arundel General</i>				d. STREET ADDRESS <i></i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>CHARLES</b>	Middle <b>LAW</b>	Last	4. DATE OF DEATH <b>December 9</b>	Month	Day Year <b>19 56</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>April 8, 1882</i>	9. AGE (In years last birthday) <b>74 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10g. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired R.R. Conductor</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>R.R. Conductor</i>	11. BIRTHPLACE (State or foreign country) <i>Penn.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Law</i>				14. MOTHER'S MAIDEN NAME <i>Johnston</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 17. INFORMANT <i>Charles C. Law Jr. (Son)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i></i>							
DUE TO (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		Month <b>12</b>	Day <b>18</b>	Year <b>1956</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>12-8</b> , 19 <b>56</b> , to <b>12-8</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12-8</b> , 19 <b>56</b> , and that death occurred at <b>1045</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James R. Martin</i>				ADDRESS (Street, city or town, state) <i>Annapolis, Md.</i>			
PHYSICIAN'S NAME (Type) <i>JAMES R. MARTIN</i>				DATE SIGNED <i>12-9-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec 11/1956</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Carrer Memorial Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Bethsville</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Wm Lee's Sons Co. 300 4th St. N.E. Wash. D.C.</i>				ADDRESS <i></i>			
24a. REC'D BY REGISTRAR DATE <i>DEC 12 1956</i>				24b. REGISTRAR'S SIGNATURE <i>John J. French</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81. PROMOTION-TRANSITION AND STATE CHANGES

BUREAU V. S.

DEC 12 1956

REGGAE IV EDO

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12053

## 12081 CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena P. O.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena P. O.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ft. Smallwood Rd.</b>		e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Minnie M. Lennox</b>		First	Middle			
4. DATE OF DEATH <b>December 15 1956</b>	Month	Day	Year			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/27/1880</b>	9. AGE (in years last birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Talbot Co., Md.</b>		
13. FATHER'S NAME <b>John Wesley Helsby</b>		14. MOTHER'S MAIDEN NAME <b>Mulligan</b>		12. CITIZEN OF WHAT COUNTRY? <b>Address</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Jesse S. Lennox, Sr. Pasadena P. O., Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b> DUE TO <b>(c)</b>		<b>cerebral hemorrhage</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>		
		<b>Hypertension</b>		10 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>		
21. I certify that I attended the deceased from <b>January 15, 1956</b> , to <b>December 15, 1956</b> , that I last saw the deceased alive on <b>December 15, 1956</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>R. M. McLaughlin</b> PHYSICIAN'S NAME (Type) <b>R. M. McLaughlin M.D.</b>		ADDRESS (Street, city or town, state) <b>Pasadena, Md.</b>		DATE SIGNED <b>Dec 16, 1956</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12/19/56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC. 715 Light St.</b>		ADDRESS <b>Baltimore-30, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 19 1956</b>		
				24b. REGISTRAR'S SIGNATURE <b>L. J. DeLaney</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED
SERIALIZED	FILED	MAILED
FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE WASHINGTON, D. C.		
DECEMBER 19, 1956		

BUREAU U. S.

DEC 19 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12082

## CERTIFICATE OF DEATH

12054

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Anne Arundel MARYLAND		a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Magrath Manor Arnold		1 yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Arnold		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle
Louisa Mary Long			
4. DATE OF DEATH		Month	Day Year
Dec. 27		1956	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F		W	B. DATE OF BIRTH
			June 19, 1869, 87 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		Home	Baltimore
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Bernard Fortman		Bernadine ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT	
no		Son Francis J. Long	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
Myocardial Infarction			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Generalized arteriosclerosis.	
DUE TO			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12/27/55</u> , 19 <u>55</u> , to <u>Dec. 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27/85</u> , 19 <u>56</u> , and that death occurred at <u>9:25P</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Robert R. Hahn M.D. Severna Park, Md.	
ACTUAL SIGNATURE		DATE SIGNED <u>12-27-56</u>	
PHYSICIAN'S NAME (Type)		Robert R. HAHN	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 27/56	
22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Harry F. Nibley, 4101 Edmondson		ADDRESS Our	
		24a. REC'D BY REGISTRAR DATE	
		24b. REGISTRAR'S SIGNATURE John H. Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be referred by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V.

JAN 3 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12055

12047

## CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				
<i>Anne Arundel</i> MARYLAND		<i>Maryland</i> <i>Laurel</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY				
<i>Annapolis</i>	RURAL	<i>Laurel</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
<i>A. U. General Hosp.</i>	X					
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
<i>Ada</i>	<i>Arvel</i>	<i>Magnuder</i>	<i>12</i>			
4. DATE OF DEATH	Month	Day	Year			
			<i>1956</i>			
S. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
<i>Female</i>	<i>Ck.</i>	<i>WIDOWED</i> <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>7-25-1904</i>	<i>52</i>	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<i>Domestic</i>		<i>Days Store</i>		<i>Bristol, Md.</i>		<i>U.S.A.</i>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			Address	
<i>David Bras</i>		<i>Mary Jane Bias</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		INTERVAL BETWEEN ONSET AND DEATH
<i>No</i>		<i>212-34-6764</i>		<i>Joseph Magnuder</i>		<i>4 hours</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		cerebral hemorrhage				
33IX		DUE TO				
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last.		by pertussis				
{ (b)		after pneumonia				
DUE TO						
(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> At work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
19						
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above.		ADDRESS (Street, city, or town, state)			DATE SIGNED	
ACTUAL SIGNATURE		<i>Emily H. Inham</i> M.D.			<i>Laurel</i> <i>12-4-56</i>	
PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)
<i>Burial</i>		<i>12-4-56</i>		<i>Zion</i>		<i>Laurel, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS				
<i>William Lee Jr.</i>		<i>Annapolis, Md.</i>				
VS A1S (4) 1SM 9/55		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE		
		<i>F.C. 6</i>		<i>Dr. J. J. French</i>		

DEPARTMENT OF HEALTH—BALTIMORE CITY

CERTIFICATE OF DEATH

BUREAU V. F.  
REGELY EO  
DEC 6 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Same</b>		b. COUNTY <b>Same</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>P.O. Pasadena</b>		c. LENGTH OF STAY IN 1b <b>26 y.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>		d. STREET ADDRESS <b>Same</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Lake Shore Drive</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>George</b>	Middle <b>Henry</b>	Last <b>Mank</b>	4. DATE OF DEATH <b>December 9th.</b>	Month <b>1956</b>	Day	Year		
5. SEX <b>M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 11/10/94</b>	9. AGE (In years from birthday) <b>62 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumbing and Heating Inspector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A.A. Col Baltimore, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>George Henry Mank</b>		14. MOTHER'S MAIDEN NAME <b>Thereasa Keene</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Robert Mank (son)</b>		Address <b>RFD 5 Box 491 Pasadena</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>Md.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		Month, Day, Year <b>Dec. 11, 1956</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Glen Haven Mem. Pk.</b>	20f. (City or town) <b>Glen Burnie</b>	(County) <b>Maryland</b>	(State) <b>Maryland</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Gustave H. Faubert, M.D.</i>	DATE SIGNED <b>12/9/56</b>								
EXAMINER'S NAME (Type) <b>Gustave H. Faubert, M.D.</b>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 11, 1956</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Glen Haven Mem. Pk.</b>	22d. LOCATION (City, town, or county) <b>Glen Burnie</b>	(State) <b>Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>George J. Gorcey</i>	ADDRESS <b>4001 Ritchie Hwy.</b>	24a. REC'D BY REGISTRAR <b>12/13/56</b>	24b. REGISTRAR'S SIGNATURE <i>L. J. Deally</i>						

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

DEPARTMENT OF HEALTH-ENVIRONMENT  
WISCONSIN DEPARTMENT OF DEATH

BUREAU V.

REG 14 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12057

## 12084 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN lb <b>20yrs.7mos. 1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		d. STREET ADDRESS <b>517 N. Carrollton St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Stephen</b>	Middle	Last <b>Matthews</b>	4. DATE OF DEATH	Month <b>12</b>	Doy <b>12</b>	Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/20/99</b>	9. AGE (In years last birthday) <b>57 yrs.</b>	IF UNDER 1 YEAR Months <b>-</b>	IF UNDER 24 HRS. Days <b>-</b>	Hours <b>-</b>	Min. <b>-</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unk.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		
13. FATHER'S NAME <b>Virgil Matthews</b>			14. MOTHER'S MAIDEN NAME <b>Mary Etta Scott</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hosp. Crownsville, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lung Abscess</b> DUE TO 002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Pulmonary Tuberculosis</b> DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Post dental infection, Dehydration</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>778</b>	(County) <b>19 56</b>	(State) <b>12/12</b>		
21. I certify that I attended the deceased from <b>778</b> , 19 <b>56</b> , to <b>12/12</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12/12</b> , 19 <b>56</b> , and that death occurred at <b>10:05A.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>							ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b>	DATE SIGNED <b>12/12/56</b>
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>								
22a. BURIAL, CREMATION REMOVAL (Specify) <b>12 - 17-56</b>	22b. DATE THEREOF <b>12 - 17-56</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Arbutus Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Alexander</b>		ADDRESS <b>2700 Edmondson Ave.</b>	24a. REC'D BY REGISTRAR DATE <b>26 M. Joyce</b>					
			24b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12058

## 12048 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AA Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>H.32 STATE St.</u>		d. STREET ADDRESS <u>432 STATE ST.</u> 1	
3. NAME OF DECEASED (Type or print) <u>MAURICE E. MEADE</u>	First	Middle	Last
4. DATE OF DEATH	Month <u>12</u>	Day <u>20</u>	Year <u>1956</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-20-1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.	10. IF UNDER 1 YEAR <input type="checkbox"/> Months	11. IF UNDER 24 HRS. <input type="checkbox"/> Days	12. IF UNDER 24 HRS. <input type="checkbox"/> Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COURTCLER</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>RICHARD G. MEADE</u>	14. MOTHER'S MADDEN NAME <u>Annie Hutchins</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>219-37-1909</u>	17. INFORMANT <u>FLORENCE MEADE #2</u>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tuberculosis</u> DUE TO <u>008X</u> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. _____	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Baltimore</u> (County) <u>Maryland</u> (State) <u>Maryland</u>
21. I certify that I attended the deceased from <u>Jan 53</u> , 19_____, to <u>1-10</u> , 19_____, that I last saw the deceased alive on <u>12/22/56</u> , 19_____, and that death occurred at <u>8A M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Glenelg, Maryland</u> DATE SIGNED <u>12/22/56</u>			
ACTUAL SIGNATURE <u>E. Linhardt</u>	M.D. <u>E. Linhardt</u>		
PHYSICIAN'S NAME (Type) <u>E. Linhardt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 12-22-56</u>	22b. DATE THEREOF <u>12-22-56</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>CEDAR Bluff</u>	22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>	ADDRESS <u>Annapolis, Md.</u>	24a. REC'D BY REGISTRAR <u>DEC 22 1956</u>	24b. REGISTRAR'S SIGNATURE <u>John M. Taylor &amp; Sons</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

27

RECEIVED

BUREAU X

DEC 26 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5, 6, 10, Block 22, Film G211 2-28-51 et

13121

## CERTIFICATE OF DEATH

Reg. Dist. No.

26

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McKendree</b>		c. LENGTH OF STAY IN 1b <b>2 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Francis</b>		First <b>Francis</b>	Middle <b></b>
4. DATE OF DEATH <b>Medley</b>	Month <b>Dec.</b>	Day <b>27</b>	Year <b>1956</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 12, 1896</b>
8. AGE (In years last birthday) <b>60 yrs.</b>		9. IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tobacco</b>	11. BIRTHPLACE (State or foreign country) <b>T.B., Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Frank Medley</b>		14. MOTHER'S MAIDEN NAME <b>Mary Thomas</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Theresa Scott, Lothian, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).  <i>151X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b). DUE TO <i>Cancer of Stomach</i> (c). DUE TO <i>Cancer of Stomach</i> INTERVAL BETWEEN ONSET AND DEATH <i>About 2 years</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year 1956
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>62 Cathedral Street</b>	(County) <b>Annapolis</b>
(State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>10-21</b> , <b>1956</b> , to <b>12-27</b> , <b>1956</b> , that I last saw the deceased alive on <b>12-26-56</b> , <b>1956</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G.T. Colby</i>		ADDRESS (Street, city or town, state) <b>62 Cathedral Street, Annapolis, Md.</b>	DATE SIGNED <b>2-5-77</b>
PHYSICIAN'S NAME (Type) <b>A. T. Allen</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Mary's</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12-31-56</b>	22d. LOCATION (City, town, or county) <b>Piscataway, Md.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bernard Hardesty</b>		24a. REC'D BY REGISTRAR <b>FEB 11 1957</b>	24b. REGISTRAR'S SIGNATURE <i>LaBelle Dent</i>
VS A15 (4) 15M 9/55 mnb		ADDRESS <b>Galesville, Md.</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1/27/57  
15M 9/55  
mnb

## CERTIFICATE OF DEATH

BUREAU X.

FEB 11 1957

RECEIVED

Replacement certificate  
Original apparently lost in mail - 2/11/57  
MS.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12059

## 12049 CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL and give nearest town Annapolis</i>		c. LENGTH OF STAY IN 1b <i>Mayo</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION <i>Anne Arundel General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>WILLIAM</i>	Middle <i>D</i>	Last <i>MORGAN</i>
4. DATE OF DEATH	Month <i>DECEMBER</i>	Day <i>19</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>Dec. 11, 1912</i>
8. WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <i>44 yrs.</i>	10. IF UNDER 1 YEAR Months <i> </i>
11. IF UNDER 24 HRS. Days <i> </i>	12. IF UNDER 24 HRS. Hours <i> </i>	13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	14. MOTHER'S MAIDEN NAME <i>Mabel ( Unknown )</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Electronics</i>	
10c. BIRTHPLACE (State or foreign country) <i>N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Morgan</i>		14. MOTHER'S MAIDEN NAME <i>Mabel ( Unknown )</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yr. no. or unknown) <i>Yes 1929</i>		16. SOCIAL SECURITY NO. <i>216-12-6941</i>	
17. INFORMANT <i>Mrs Elara W. Morgan- Wife- same as # 2</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerotic coronary artery disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>16 hours</i>	
(b) DUE TO <i>ARTERIOSCLEROTIC CORONARY ARTERY DISEASE</i>		1 YEAR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.      20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>19 DEC</i> , 1956, to <i>19 DEC</i> , 1956, that I last saw the deceased alive on <i>19 DEC</i> , 1956, and that death occurred at <i>9 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward J. Beck</i>		ADDRESS (Street, city or town, state) <i>Southgate Ave. Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Edward J. Beck M.D.</i>		DATE SIGNED <i>12/21/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>12-22-1956</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Crematory</i>		22d. LOCATION (City, town, or county) (State) <i>Prince George County Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		ADDRESS <i>Annapolis, Md.</i>	
24a. REC'D BY REGISTRAR <i>12/22/56</i>		24b. REGISTRAR'S SIGNATURE <i>John Hopping</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VS A15 (4)  
15M 9/55

81. *ЭКОНОМИКА—БИЗНЕС В УЧЕБНО-ПРАКТИЧЕСКОМ СОСТАВЕ*

BUREAU V. S.

DEC

REGEL

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12060

12087

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE						
<i>Towson Arundel MARYLAND</i>		<i>Maryland A.A. Co.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY						
<i>Edgewater</i>								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
<i>Rt 1 Box 467</i>	<i>Edgewater</i>							
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
<i>Richard</i>			<i>A. Neale</i>	<i>12</i>	<i>12</i>	<i>1956</i>		
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years (including birthday))	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.		
<i>Male</i>	<i>Col.</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>17-4-1870</i>	<i>86</i> yrs.	Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
<i>Farmer</i>		<i>Self-employed</i>		<i>Mayo, Md</i>		<i>U.S.A.</i>		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address				
<i>Richard A. Neale</i>		<i>Ellen Boston</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		
(If yes, give war or dates of service)		<i>        </i>		<i>Jane Neale - Rt 1 Box 467 Edgewater Md</i>		<i>Cerebral Hemorrhage</i>		
IMMEDIATE CAUSE (a)		DUE TO		INTERVAL BETWEEN ONSET AND DEATH				
<i>331X</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)						
{		DUE TO						
(c)								
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		White at work	Not white at work					
<i>6-10-56 19</i>		<input type="checkbox"/>	<input type="checkbox"/>					
21. I certify that I attended the deceased from <i>6-10-56</i> , 19, to <i>12-12-56</i> , 19, that I last saw the deceased alive on <i>12-10-56</i> , 19, and that death occurred at <i>6-10-56</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)			DATE SIGNED			
ACTUAL SIGNATURE <i>J. Cullen</i>		<i>6-12 Cathedral 12-14-56</i>						
PHYSICIAN'S NAME (Type) <i>P.T. ALLEN</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
<i>Cremation</i>		<i>12-15-56</i>		<i>Chesapeake Cremerville, Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
<i>William Reese, Jr. Annapolis</i>				<i>REC'D 12-15-56</i>		<i>by J. Cullen</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V.

DEC 26 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12061

12088

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		
<i>Anne Arundel Co. MARYLAND</i>		<i>Md. AA</i>		
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
<i>Linthicum Heights</i>		<i>Linthicum Heights</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS			
<i>112 Sycamore Rd.</i>	<i>112 Sycamore Road</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
<i>MARY CATHERINE O'CONNOR</i>				
4. DATE OF DEATH	Month	Day	Year	
	<i>12</i>	<i>7</i>	<i>56</i>	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	
<i>Female</i>	<i>White</i>	<i>WIDOWED <input checked="" type="checkbox"/></i>	<i>April 17 1889</i>	
9. AGE (In years lost birthday) yrs.	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.		
<i>73</i>	Months	Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>	<i>Home</i>	<i>Annapolis Md.</i>	<i>U.S.A.</i>	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
<i>Philip Parkinson</i>	<i>Clara Meekins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address	
		<i>Lawrence J. O'Connor</i>	<i>2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	<i>Acute Cardiac Decompensation</i> <i>2 weeks</i>			
<i>592x</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	<i>Chronic Myocarditis</i> <i>3 months</i>		
	DUE TO	<i>Chronic Nephritis</i> <i>1 year</i>		
(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
<i>Aug. 7 1956</i>	<i>19</i>	<i>1609 Gov. Ridge Hwy</i>	<i>Baltimore</i>	<i>Md.</i>
21. I certify that I attended the deceased from <i>Aug. 7</i> , 19 <i>56</i> , to <i>Dec 4</i> , 19 <i>56</i> that I last saw the deceased alive on <i>Dec 4, 1956</i> , and that death occurred at <i>3:40 P.M.</i> from the causes and on the date stated above.	ADDRESS (Street, city or town, state)			DATE SIGNED
ACTUAL SIGNATURE <i>P.J. Grimaldi</i>	M.D.	<i>1609 Gov. Ridge Hwy Baltimore 25 Md.</i> <i>12-8-56</i>		
PHYSICIAN'S NAME (Type)	<i>P.J. Grimaldi</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>12-10-56</i>	<i>St. Mary's</i>	<i>Annapolis</i>	<i>Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE	
<i>John M. Taylor Sons</i>	<i>Annapolis Md.</i>	<i>J. M. Brumich</i>		

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STATE OF MARYLAND - BALTIMORE CITY

CERTIFICATE OF DEATH

RECEIVED

DEPT. OF

BUREAU V. S.

DEC 12 1956

REGEIV E

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film G210 1-29-57 et

12062

## 12050 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i>		b. COUNTY <i>Annapolis</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN lb <i>1b</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>710 Second St.</i>		10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Aime Arundel Hospital</i>		d. STREET ADDRESS <i>Annapolis Rd.</i>		d. DATE OF DEATH <i>PARKER</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARY FRANCES ELIZABETH D.</i>		First	Middle	Last	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 20 1829</i>		9. AGE (In years last birthday) <i>27 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>		11. BIRTHPLACE (State or foreign country) <i>EASTON MD.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Augustus McDaniel</i>		14. MOTHER'S MAIDEN NAME <i>Edna</i>		Address <i>Second St. Annapolis Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219 32 4075</i>		17. INFORMANT <i>JAMES Harrison Parker</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Acute Cardiac Failure</i> DUE TO (b) <i>Mitral Heart Disease</i> DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>62 Cathedral St Annapolis Md</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12-6-16</i> , 19_____, to <i>12-10-16</i> , 19_____, that I last saw the deceased alive on <i>12-10-16</i> , 19_____, and that death occurred at <i>926 1/2 Cathedral St</i> , M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>A.T. Allen</i> PHYSICIAN'S NAME (Type) <i>A.T. Allen</i>				ADDRESS (Street, city or town, state) <i>Annapolis Md</i>		DATE SIGNED <i>12-14-16</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>12/14/56</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Adams Chapel</i>		22d. LOCATION (City, town, or county) <i>Baltimore Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty Galiville Lead</i>		ADDRESS <i>Bernard Hardisty Galiville Lead</i>		24a. REC'D BY REGISTRAR DATE <i>10 - 0. Driscoll</i>		24b. REGISTRAR'S SIGNATURE <i>0. Driscoll</i>	

## FORM 11 - CERTIFICATE OF DEATH

DECEMBER 1951

DECEMBER 1951

DECEMBER 1951

BUREAU Y. S.

DEC 21 1951

REGISTRY BUREAU

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

12063

**CERTIFICATE OF DEATH**

12089

Reg. Dist. No. 70

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY Anne Arundel CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Gambrills		MARYLAND LENGTH OF STAY (In this place) 32 yrs.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills STREET ADDRESS (If rural give location)	
Florida & California Avenues Florida & California, Avenues		Florida & California Avenues Florida & California, Avenues	
<b>3. NAME OF DECEASED (Type or Print)</b>		<b>4. DATE OF DEATH</b>	
SAMUEL LOUIS PETERS		Dec. 24, 1956	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	Married	Feb. 1, 1882
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
74	Toreman	Queen Anne's Co. Md.	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
John Peters	Ida Boyles		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.		
No	215-05-7267		
17. INFORMANT & ADDRESS		18. MEDICAL CERTIFICATION	
Mrs. Carrie A. Peters. Same as #2		INTERVAL BETWEEN ONSET AND DEATH	
3 M/o		3 M/o	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
IMMEDIATE CAUSE (A) <i>Generalized Cervinomatosis</i>		162X	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Bronchogenic Carcinoma</i>		3 M/o	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. HOW DID INJURY OCCUR?	
M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
<b>22. I hereby certify that I attended the deceased from Oct. 19, 1956, to Dec. 24, 1956, that I last saw the deceased alive on Dec. 23, 1956, and that death occurred at 8:30 P.M. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <i>Edward J. Shemtov</i>		<b>ADDRESS</b> (Street, city, town, state) <i>Gambrills Md</i>	
		<b>DATE SIGNED</b> <i>12-25-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		M.D.	
Burial		NAME OF CEMETERY OR CREMATORIAL <i>Glen Haven Cemetery</i>	
DATE <i>Dec. 28, 1956</i>		LOCATION (City, town, or county) <i>Glen Burnie, Maryland</i>	
24. REG'D BY REGISTRAR <i>J. M. Hayes</i>		REGISTRAR'S SIGNATURE	
DATE <i>Dec. 28, 1956</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Richard J. Lightfoot</i>	
		ADDRESS <i>Glen Burnie, Maryland</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12051

## CERTIFICATE OF DEATH

12064  
21

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) U.S. Naval Hospital	c. LENGTH OF STAY IN lb 15 min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Severna Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.		d. STREET ADDRESS 501 Pine Tree Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Robert William PETTY		4. DATE OF DEATH December 10 1956	Month Day Year
S. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 August 1900
9. AGE (In years lost birthday) 56 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy		10b. KIND OF BUSINESS OR INDUSTRY Ret.	11. BIRTHPLACE (State or foreign country) S.C.
13. FATHER'S NAME Deceased-Unknown		14. MOTHER'S MAIDEN NAME Deceased; Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES <input checked="" type="checkbox"/> 1919-1946		16. SOCIAL SECURITY NO. 282-18-8217	17. INFORMANT U.S. Naval Records Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Coronary Occlusion, Anterior descending Half-hour DUE TO (c) branch, left # 420.1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-10, 1956, to 12-10-, 1956, that I last saw the deceased alive on 12-10-56, 1956, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Vincent P. Butler, Jr. M.D. DATE SIGNED 12-10-56			
PHYSICIAN'S NAME (Type) Vincent P. Butler Jr Lt. MC USN U.S. Naval Hospital, Annapolis, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-13-56	22c. NAME OF CEMETERY OR CREMATORIUM Glen Haven Cemetery	22d. LOCATION (City, town, or county) Glen Burnie, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE NOTIFYING FUNERAL HOME ANNAPOLIS, MD.		24a. REC'D BY REGISTRAR DATE 12-12-56	24b. REGISTRAR'S SIGNATURE L. French

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE GOVERNOR'S OFFICE  
CERTIFICATE OF DEATH

BUREAU Y.  
REC'D BY  
DEC 14 1956  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12065

12090

## CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH a. COUNTY  Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE  Maryland b. COUNTY  3 v o 1 - 4 ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL, and give nearest town Crownsville, Md.		c. LENGTH OF STAY IN 1b 20 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Fairfield)	
d. STREET ADDRESS 3208 STATE ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Lucille	Middle Queen	Last 12 24 19 56
4. DATE OF DEATH	Month	Day	Year
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4-23-1905 51
8. AGE (In years last birthday) yrs. Months Days Hours Min.	9. IF UNDER 1 YEAR Months	10. IF UNDER 24 HRS. Hours	11. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Chas. County, Md.	
13. FATHER'S NAME Joseph Palmer		12. CITIZEN OF WHAT COUNTRY? Address Crownsville, Md.	
14. MOTHER'S MAIDEN NAME Lucey Hawkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Hospital Records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Left Hemiplegia due to Hypertensive Cardio - vascular disease. DUE TO (c) Pneumonitis	
		INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20. TIME OF INJURY Hour o. m. ----- 19 p. m. -----		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) (State) -----	
21. I certify that I attended the deceased from Dec. 4th, 1956, to Dec. 24th, 1956, that I last saw the deceased alive on 12/24/56, 1956, and that death occurred at 3:30 p.m., from the causes and on the date stated above. ACTUAL SIGNATURE Leonel McHenry Mapp M.D. Crownsville State Hospital, Md.		22. DATE SIGNED December 24, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/23/56	
22c. NAME OF CEMETERY OR CREMATORIUM Mt. Calvary CEM.		22d. LOCATION (City, town, or county) A.A. County Mol.	
23. FUNERAL DIRECTOR'S SIGNATURE Milton E. Erickson		24a. REC'D BY REGISTRAR DATE DEC 27 1956	
ADDRESS 1129 N. CAROLINE		24b. REGISTRAR'S SIGNATURE H. M. Lovette	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

87-3900740-112AF. NO TRAINING AND STATE CANVASS

4

A black and white photograph of a man in a suit and tie, looking slightly to his left. The word "RECEIVED" is printed across the bottom of the frame, and "BUREAU V. S." is printed diagonally across the top.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G208 12-27-56 et

12066

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY	12091		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	West Gate		c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Lawrence Ave		d. STREET ADDRESS	West Gate			
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Male	Russell	William	Racey	4-30-1892	1956	9	1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH	9. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
Male	White		4-30-1892	63 yr.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?			
Carpenter	Construction Work		West Va	U.S.A.			
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
Charles Racey	Leuna Hemmel Wright						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.		17. INFORMANT	Address			
	218-12-9639		Nellie C. Racey	(2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)							
783.1							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO							
(b)							
DUE TO							
(c)							
Culmonary Hemorrhage sudden							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. Linhardt</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 12/10/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-13-56	22c. NAME OF CEMETERY OR CREMATORIALY Hillcrest	22d. LOCATION (City, town, county) Baltimore	(State) Md			
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons	ADDRESS Omniapolis, MD	24a. REC'D BY REGISTRAR 12/12/56	24b. REGISTRAR'S SIGNATURE V. Drueck				

BUREAU V. A

DEC 13 1956

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

12067

**CERTIFICATE OF DEATH**

Reg. Dist. No.....

**1. PLACE OF DEATH**

12092

COUNTY Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR end give nearest town)

TOWN North Linthicum

LENGTH OF STAY  
(in this place)

18 mos.

HOSPITAL  
INSTITUTION OR  
STREET ADDRESS

#209 Devon Court

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE Maryland

COUNTY Anne Arundel

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN North Linthicum

STREET  
ADDRESS

#209 Devon Court

**3. NAME OF  
DECEASED**  
(Type or Print)

Anne

A.

Ray

(Last)

**4. DATE  
OF  
DEATH**

Dec. 21,

19

56

5. SEX

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

8. DATE OF BIRTH

9. AGE last birthday  
yrs.IF UNDER 1 YEAR  
Months Days Hours Min.

Female

White

Single

May 14, 1879

77

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Housework

10b. KIND OF BUSINESS  
OR INDUSTRY

own home

11. BIRTHPLACE (State or foreign country)

Anne Arundel Co., Md.

12. CITIZEN OF WHAT  
COUNTRY?  
U.S.A.

13. FATHER'S NAME

John H. Ray

14. MOTHER'S MAIDEN NAME

Sarah Magruder

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

no

--

16. SOCIAL SECURITY NO.

none

17. INFORMANT &amp; ADDRESS

Mr. Thales C. Pumphrey Same As 2

**I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

451X

IMMEDIATE CAUSE

(A)

Abdominal Aneurism in Descending Aorta

INTERVAL BETWEEN  
ONSET AND DEATH

sev. yrs.

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY,  
GIVING RISE TO THE ABOVE CAUSE  
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.**

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES  NO 21e. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY

(Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED

M. While at work  Not while at work 

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from.....

19 20, to Dec. 21, 1956.....

that I last saw the deceased

alive on Dec. 21, 1956, and that death occurred at.....M, from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORI

LOCATION (City, town, or county)

(State)

Burial

Dec. 24/56

Cedar Hill Cemetery

Brooklyn, RFD, Maryland

24. REG'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

DATE

Dec. 20/56

d. H. Hanch

Robert W. Langford

Glen Burnie, Md.

BUREAU A.

DEC 26 1966

**SEGELVED**

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12068

## 12093 CERTIFICATE OF DEATH

Reg. Dist. No. 27

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AIFC 155 10M

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Anne Arundel Fort George G. Meade U. S. Army Hospital	MARYLAND LENGTH OF STAY (in this place)	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore STREET ADDRESS 1318 Myrtle Avenue
HOSPITAL OR INSTITUTION OR STREET ADDRESS			
<b>3. NAME OF DECEASED (First) ROMONA</b>		<b>(Middle) RYDER</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>December 19, 1956</b>
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	9. AGE last birthday Yrs. <b>9</b>
13. FATHER'S NAME <b>Marvin Ryder</b>	14. MOTHER'S MAIDEN NAME <b>Joyce Margaret Bell</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT & ADDRESS <b>Mother, 1318 Myrtle Avenue, Baltimore, Maryland</b>	18. MEDICAL CERTIFICATION <b>IMMURITY</b>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 hrs 25 min.</b>	
776 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	<b>Dummaturity</b>		
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
19e. DATE OF OPERATION <b>No operation</b>	19b. MAJOR FINDINGS OF OPERATION <b>No operation</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <b>No injury</b>	21c. WHERE DID INJURY OCCUR? (City or town) <b>No injury</b>	(County) <b>Baltimore</b> (State) <b>Md.</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>18 Dec 56</b>	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>No injury</b>	
<b>22. I hereby certify that I attended the deceased from 18 Dec 56 to 19 Dec 56, that I last saw the deceased alive on 19 Dec 56, and that death occurred at 0810 AM from the causes and on the date stated above.</b>			
SIGNATURE <i>RICHARD N. MCGUIRE, CAPT. M.D.</i>	ADDRESS (Street, city, town, state) <b>0810 AM</b> DATE SIGNED <b>19 Dec 56</b>		
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>24 Dec 56</b>	NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>	LOCATION (City, town, or county) <b>Baltimore, Md</b> (State)
24. REC'D BY REGISTRAR <b>William L. Saylor, 1st Lt.</b>	REGISTRAR'S SIGNATURE <i>William L. Saylor</i>	25. FUNERAL DIRECTOR'S SIGNATURE <b>MSC</b>	ADDRESS <i>2250222 XVO</i>
DATE <b>19 Dec 56</b>	WILLIAM L. SAYLOR, 1ST LT,	A.S. PHILLIPS, Baltimore, Md.	

WISCONSIN STATE DEPARTMENT OF AGED - ALZHEIMER'S DISEASE

STATEMENT OF DEATH

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SUREAU V. S.

DEC 27 1956

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 13,14 Film G209 1-14-57 et

## 12094 CERTIFICATE OF DEATH

12069

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Anne Arundel Fort George G. Meade U. S. Army Hospital U.S Army Hosp. Ft. Meade	MARYLAND LENGTH OF STAY (In this place) 43 days	Maryland Maryland Howard CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS 34 Hunt Club Road 34 Hunt Club Rd.
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b> (Month) Decemeber (Day) 30 (Year) 56	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 1884 13 August 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Soldier		10b. KIND OF BUSINESS OR INDUSTRY U. S. Army	9. AGE last birthday 72 yrs. 72
13. FATHER'S NAME Unknown		11. BIRTHPLACE (State or foreign country) Wilkes-Barre, Pennsylvania	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. 214-20-9871	17. INFORMANT & ADDRESS Mrs. Agnes Spahn 34 Hunt Club Road, Elkridge, Md.
<b>18. MEDICAL CERTIFICATION</b> I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 332X IMMEDIATE CAUSE (A) Cerebral Thrombosis and Terminal Pneumonia ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from.....17 Nov....., 19..56....., to.....30 Dec....., 19..56....., that I last saw the deceased alive on.....30 Dec....., 19..56....., and that death occurred at.....M, from the causes and on the date stated above. SIGNATURE JOHN L. ROBERTSON, CAPT, MC, M.D. DATE SIGNED 30 Dec 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/3/1957	NAME OF CEMETERY OR CREMATORIUM Baltimore National Cem.
24. REC'D BY REGISTRAR DATE 31 Dec 56		REGISTRAR'S SIGNATURE W.L. SAYDOR, 1ST LT, MSC	LOCATION (City, town, or county) Baltimore, Md.
		25. FUNERAL DIRECTOR'S SIGNATURE Elsworth Armacost	ADDRESS Ave, Baltimore, Md.
			Elsworth Armacost, 4600 Liberty Heights



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12052 CERTIFICATE OF DEATH

12070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A.A. Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>A.A. Co.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Annapolis</i>		d. STREET ADDRESS <i>BEST GATE RD.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.A. GENERAL Hosp.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>FLORENCE</i>	Middle <i>MABEL</i>	Last <i>SEARS</i>	4. DATE OF DEATH 12	Month 12	Day 3	Year 1956
S. SEX <i>f</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/24/1888</i>	9. AGE (In years last birthday) <i>68</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOME</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOUSEWIFE</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Ella Hildibrant</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>BENJAMIN F. SEARS</i>		Address <i>#2</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CORONARY occlusion</i> DUE TO <i>420.0</i> INTERVAL BETWEEN ONSET AND DEATH <i>4 Hours</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO <i>Unknown</i> (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>APRIL, 1955</i> , to <i>3 DEC, 1956</i> , that I last saw the deceased alive on <i>3 DEC, 1956</i> , and that death occurred at <i>9:30 PM</i> , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Edward S. Beck</i> M.D. ADDRESS (Street, city or town, state) <i>41 Southgate Ave., Annapolis, Md.</i> DATE SIGNED <i>12/4/56</i>								
PHYSICIAN'S NAME (Type) <i>Edward S. Beck M.D.</i>		41 Southgate Ave., Annapolis, Md.						
22a. BURIAL, Cremation, Removal (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>12/5/1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>EDWARDS CHAPEL</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Lytle &amp; Sons</i>		ADDRESS <i>Annapolis, Md.</i>		24a. REC'D BY REGISTRAR <i>-</i>		24b. REGISTRAR'S SIGNATURE <i>John W. Lytle &amp; Sons</i>		

## CERTIFICATE OF DEATH

Date Issued:

Place of Death:

Name of Hospital:

Name of Doctor:

Name of Mortician:

Name of Coroner:

Name of Sheriff:

Name of Clerk:

Name of Sheriff's Deputies:

RECEIVED  
BUREAU Y. S.

DEC 6 1955

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12071

12095

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Winchester, Annapolis, Md</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Winchester, Annapolis, Md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS Box 140. R.F.D. 4	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>W.</i>	Last <i>Sheppach</i>
4. DATE OF DEATH	Month <i>Dec</i>	Day <i>23</i>	Year <i>1956</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>May 5, 1873</i>
8. AGE (In years (last birthday) yrs. <i>83</i>		9. IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>(Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Coal Business</i>	11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>George Sheppach</i>		14. MOTHER'S MAIDEN NAME <i>Helena Emrich</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>	17. INFORMANT Address <i>Mrs. John Fitzpatrick, Winchester, Annapolis, Md</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1 Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiovascular disease</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>1/2 hr.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June 15, 1956</i> , to <i>Dec 23, 1956</i> , that I last saw the deceased alive on <i>Dec 23, 1956</i> , and that death occurred at <i>6:45 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Ames Garrett Blvd., Annapolis, Md.</i> <i>1956</i>			
ACTUAL SIGNATURE <i>S. Borsuck</i>		M.D. PHYSICIAN'S NAME (Type) <i>S. BORSUCK</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12-26-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Moreland Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Cook, Inc., 1217 St. Paul Street</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE <i>DEC 27 1956</i>	
		24b. REGISTRAR'S SIGNATURE <i>Wm J French</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be released by the hospital or attending physician to the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

BUREAU V. S.

DEC 27 1956

РЕГЕЛИВ

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12072

12096

## CERTIFICATE OF DEATH

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY <b>A. A.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A. A.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harman</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Harman</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>—</b>		d. STREET ADDRESS <b>—</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>DAISY</b>	Middle <b>GERTRUDE</b>	Last <b>SHIPLEY</b>
4. DATE OF DEATH	Month Dec.	Day <b>12</b>	Year <b>1956</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 24, 1876</b>
9. AGE (In years lost birthday) <b>80 yrs.</b>		10. IF UNDER 1 YEAR Months <b>—</b>	11. IF UNDER 24 HRS. Days <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife (rtd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY?		<b>Glen Burnie, Md</b>	
13. FATHER'S NAME <b>Richard Shipley</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Quail</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT <b>Mrs. Catherine S. Walter-Box 6- 107 Crain Hwy SE</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
DUE TO <b>420.1</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b>		15 years	
DUE TO <b>—</b>			
(c) <b>—</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October</b> , 1955, to <b>December</b> , 1956, that I last saw the deceased alive on <b>December 12, 1956</b> , and that death occurred at <b>11:45 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore 1 Md.</b>		DATE SIGNED	
ACTUAL SIGNATURE <b>E. Roderick Shipley</b>		M.D. <b>721 Medical Arts Bldg</b>	
PHYSICIAN'S NAME (Type) <b>E. Roderick Shipley M.D.</b>		Baltimore 1 Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/15/67</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Friendship Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Friendship, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Zichner &amp; Sons - Balt. 17</b>		24a. REC'D BY REGISTRAR DATE <b>C. 17 1956</b>	24b. REGISTRAR'S SIGNATURE <b>Clara Zichner</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 18

CERTIFICATE OF DEATH

NAME



BUREAU V.

3 17 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12073

Reg. Dist. No.

12097

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE										
<i>Anne Arundel</i> <b>MARYLAND</b>		<b>c. LENGTH OF STAY IN 1b</b> <i>Brooklyn Park</i> <i>allevia</i> <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital, give street address) <i>338 - Holy Cross Rd.</i>										
<b>e. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		<b>c. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>										
<b>d. STREET ADDRESS</b> <i>1515 37/36</i>		<b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) <i>Pamela Sue Skeens</i>		<b>First</b> <i>Pamela</i>	<b>Middle</b> <i>Sue</i>	<b>Last</b> <i>Skeens</i>	<b>4. DATE OF DEATH</b> <i>10/17/56</i>	<b>Month</b> <i>Oct</i>	<b>Day</b> <i>17</i>	<b>Year</b> <i>19</i>				
<b>5. SEX</b> <i>F</i>		<b>6. COLOR OR RACE</b> <i>W.</i>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <i>10/17/56</i>		<b>9. AGE</b> (in years last birthday) yrs. <i>2</i> months <i>10</i> days <i>0</i> hours <i>0</i> min. <i>0</i>				
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most recent working life, even if retired) <i>None</i>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Ruthieay Hospital, Baltimore, Md.</i>			<b>11. BIRTHPLACE</b> (State or foreign country) <i>Ruthieay Hospital, Baltimore, Md., U.S.A.</i>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>			
<b>13. FATHER'S NAME</b> <i>Willie T. Skeens</i>			<b>14. MOTHER'S MAIDEN NAME</b> <i>Lusie Beck</i>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <i>No</i>			<b>16. SOCIAL SECURITY NO.</b> <i>None</i>			<b>17. INFORMANT</b> <i>Mr. W. T. Skeens (mother)</i>			<b>Address</b> <i>None</i>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute pulmonary infection</i> DUE TO 527.2 Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)										<b>INTERVAL BETWEEN        ONSET AND DEATH</b> <i>24 hours</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>or CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour    o. m.    p. m. <i>19</i>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>None</i>		<b>20f. (City or town)</b> <i>None</i>		<b>(County)</b> <i>None</i>		<b>(State)</b> <i>None</i>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <i>None</i>												
<b>ACTUAL SIGNATURE</b> <i>Gustave H. Faubert</i> <b>DATE SIGNED</b> <i>12/27/56</i> <b>EXAMINER'S NAME (Type)</b> <i>GUSTAVE H. FAUBERT</i>												
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>Burial</i>		<b>22b. DATE THEREOF</b> <i>10-29-56</i>		<b>22c. NAME OF CEMETERY OR CREMATORIAL</b> <i>Cedar Hill</i>		<b>22d. LOCATION (City, town, or county)</b> <i>9.9. Co.</i>		<b>(State)</b> <i>None</i>				
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>William Cook Inc. 1817 St Paul St</i>				<b>ADDRESS</b> <i>2046 212 X V6</i>		<b>24a. REC'D BY REGISTRAR</b> <i>12-31-56</i>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Ida M. Watson</i>				

RECEIVED

DEC 6 1968

BUREAU OF

16

12074

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

12053

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		a. STATE MD b. COUNTY A.A.	
Hanna polis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
16 MARYLAND AVE		16 MARYLAND AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First CECIL	Middle ADA	Last SMITH	4. DATE OF DEATH 12 Month 11 Day Year 1956
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-1893 9. AGE (In years 63 months 0 days yrs.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) ILL.	
12. CITIZEN OF WHAT COUNTRY? U.S.					
13. FATHER'S NAME C. FRANK SMITH		14. MOTHER'S MAIDEN NAME GRACE TAYLOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -		17. INFORMANT J. NORMAN SMITH Address #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4343 DUE TO <u>liver disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>liver</u>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>liver disease</u>					
DUE TO <u>liver disease</u> (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>J. N. Smith</u>		DATE SIGNED 12/14/86			
EXAMINER'S NAME (Type) E. Linhardt		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (check)		22b. DATE THEREOF 12-13-86		22c. NAME OF CEMETERY OR CREMATORIAL CREST	
BURN				22d. LOCATION (City, town, or county) HUNTERSON	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor, Esq.		ADDRESS Annapolis, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE O. Drueck DATE 12/14/86	

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EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 18 1962

RECEIVED

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG208 12-21-56 et  
12098

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH o. COUNTY Anne Arundel County ROCK VIEW BEACH MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE BALTIMORE b. COUNTY AA.CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK VIEW BEACH	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) CATHERINE STACHELEK		4. DATE OF DEATH DEC. 13. / 56	Month Day Year 19
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 18. 1869 87
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) POLAND
13. FATHER'S NAME J. Konieczny		14. MOTHER'S MAIDEN NAME Unk,	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Adam Stachelek Son
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Anticoagulant Cardio Vasculare Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE J. Brady Smith M.D. ADDRESS (Street, city or town, state) Riverdale Beach, Md. DATE SIGNED 12/13/56			
PHYSICIAN'S NAME (Type) J. Brady Smith		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF DEC. 15/56 22c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART OF MARY BALTIMORE	
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. OZAZIEWSKI VS A15 (4) 15M 9/55		24a. REC'D BY REGISTRAR DEC. 17 1956 24b. REGISTRAR'S SIGNATURE L. J. deAlley	

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

REAU V.

CO 47 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12076

12099

## CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>15 yrs. 1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taylors Island</b>		d. STREET ADDRESS <b>None listed</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Blanche</b>	Middle <b>Waters</b>	Last <b>Stanley</b>	4. DATE OF DEATH	Month <b>12</b>	Day <b>10</b>	Year <b>19 56</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 9, 1904</b>	9. AGE (In years last birthday) <b>52 yrs.</b>	IF UNDER 1 YEAR Months - - -	IF UNDER 24 HRS. Days - - -	Hours - - -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - -		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Waters</b>		14. MOTHER'S MAIDEN NAME <b>Bertha Ennels</b>		Address <b>Crownsville State Hospital</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>Unk.</b>		17. INFORMANT <b>Hospital Records</b>		Crownsville, Maryland INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Yeast Infection of tonsils</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
21. I certify that I attended the deceased from <b>12/3</b> , 19 <b>56</b> , to <b>12/10</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>12/7</b> , 19 <b>56</b> , and that death occurred at <b>5:05 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>12/10/56</b>							
ACTUAL SIGNATURE <i>Lionel McHenry Mapp</i>	PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/13/1956</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Taylors Island</b>	22d. LOCATION (City, town, or county) <b>Taylors Island, Md.</b> (State)				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Herbert M. Selby Jr., Cambridge, Md.</i>	ADDRESS <i>Cambridge, Md.</i>	24a. REC'D BY REGISTRAR DATE <b>12/11/56</b>	24b. REGISTRAR'S SIGNATURE <i>John W. Price Jr.</i> H. M. Rogers				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

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81. ЗАКОНОДАТЕЛЬСТВО ТЮМЕНСКОЙ ОБЛАСТИ О НАУКЕ

URÉAU V. S.

১৯৫৭। ঢাকা। ৩৩

DECEMBER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12077

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>7 weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena</b>		d. STREET ADDRESS <b>RFD</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>ELIZABETH</b>	Middle <b>L.</b>	Last <b>STANLEY</b>	4. DATE OF DEATH	Month <b>December</b>	Day <b>18</b>	Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>May 3, 1910</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Spotsylvania Co., Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>(unknown) Carnohan</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Miss June Yvonne Harris</b>		Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  171X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  DUE TO (b) DUE TO (c)									
<i>Pulmonary edema</i> <i>Circulatory collapse</i> & terminal <i>Carcinoma cervix, Stage IV 6-7 yrs.</i>									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Glen Burnie</b>		(County) <b>Maryland</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from _____, 1950 to _____, 1956, that I last saw the deceased alive on <b>12/18</b> , 1956, and that death occurred at <b>M</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Dr. Christopher J.</i>		ADDRESS (Street, city or town, state) <b>69 Franklin, Annapolis 12/18/56</b>							DATE SIGNED <b>12/18/56</b>
PHYSICIAN'S NAME (Type) <b>B. Langston</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 22/56</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glen Haven Cemetery</b>		22d. LOCATION (City, town, or county) <b>Glen Burnie, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>B. Langston</i>		ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>REC'D 20/12/56</b>		24b. REGISTRAR'S SIGNATURE <i>W. L. Fenster</i>			

## CERTIFICATE OF MAIL

1950

FBI

BUREAU V. S.

DEC 26 1950

REGEL V.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12078

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Al Co.</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>Al Co.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mayo</i>		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Agnes.</i>		First <i>Agnes.</i>	Middle <i>Mary</i>	Last <i>Stromberg</i>	4. DATE OF DEATH <i>2/4/97</i>	Month <i>2</i>	Day <i>28</i>	Year <i>19 56</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/4/97</i>	9. AGE (In years last birthday) <i>59</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supervisor - Peoples Life Ins. Co.</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		
13. FATHER'S NAME <i>Thomas A. Keleher</i>		14. MOTHER'S MAIDEN NAME <i>Frances J. McElroy</i>		Address <i>Clifton Q. Stromberg husband</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>578-24-5586</i>		17. INFORMANT				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest - due to toxic</i>		DUE TO <i>170X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>8 days.</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i>		DUE TO <i>(c)</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>E. L. Wharff.</i>	EXAMINER'S NAME (Type) <i>E. L. Wharff.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>12/18/56</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>12/31/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill.</i>		22d. LOCATION (City, town, or county) <i>Gwynedd, Md.</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Halligan's Funeral Home Inc.</i>		ADDRESS <i>Mt. Rainier</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 2 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. Smith</i>			

WEDDING EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAY 2 1957

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

12079

**CERTIFICATE OF DEATH**

12101

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY AMYRE ARVNDEL MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) LENGTH OF STAY TOWN GLENBURNIE (In this place)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS PLAZA MANOR CONN. HOME				STREET ADDRESS 714 Dolphin St. (If rural, give location) Baerfo.			
3. NAME OF DECEASED (Type or Print) (First) CHARLIE (Middle) (Last) SUGARS		4. DATE OF DEATH Dec 18 (Month) (Day) (Year) 1956					
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S.	8. DATE OF BIRTH Jan 18, 1897	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balto. Md.	12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Barnes		14. MOTHER'S MAIDEN NAME Mary sugars					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If Yes, give rank.) WWI		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Addie Neal 714 Dolphin St.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE 450.0 (A) ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				18. MEDICAL CERTIFICATION ARTERIOSCLEROSIS GENERAL			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
19e. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 18, 1956, to Dec 18, 1956, that I last saw the deceased alive on Dec 15, 1956, and that death occurred at 609 M., from the causes and on the date stated above. SIGNATURE Joseph Taler M.D. ADDRESS (Street, city, town, state) 102 Balto. Arvn. Blvd. 116 Bld. DATE SIGNED Dec. 18, 1956							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 12/21/1956	NAME OF CEMETERY OR CREMATORIAL M.D. Balto. National	LOCATION (City, town, or county) Balto. Md. (State)			
24. REC'D BY REGISTRAR DATE 12/20/56		REGISTRAR'S SIGNATURE Deally		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 322 N. Mrs Katie R. Williams Schrockel St.			

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

STATE DEPARTMENT OF DEFENSE  
CENTRAL INTELLIGENCE

RECEIVED  
DECEMBER 21 1956  
FBI - NEW YORK

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13104

12102

## CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>25 yrs. 2 mos. 28 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>		3 VO 1.4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Stump Alley</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Mary</b>	Middle	Last <b>Tasker</b>	4. DATE OF DEATH <b>12</b>	Month <b>12</b>	Day <b>29</b>	Year <b>1956</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Not listed</b>	9. AGE (In years last birthday) <b>75?</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Nathaniel Tasker</b>		14. MOTHER'S MAIDEN NAME <b>Esther Ann Goldberg</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unk.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Hospital Records</b>		Address <b>Crownsville State Hospital Crownsville, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-vascular Accident</b>		INTERVAL BETWEEN ONSET AND DEATH					
33 IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Senile Arteriosclerosis with Hypertension</b>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypostatic Pneumonia with Pyelonephritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		Month, Day, Year <b>1956</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Crownsville, Md.</b>	(County) <b>Anne Arundel Co.</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>11/22/1956</b> to <b>12/29/1956</b> , that I last saw the deceased alive on <b>12/28/1956</b> , and that death occurred at <b>11:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>12/29/56</b>							
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b>							
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1-4-57</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>University of Md.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, Jr. - Annapolis, Md.</b>		ADDRESS <b>1010 10th Street, Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10 1957</b>		24b. REGISTRAR'S SIGNATURE <b>H. M. Hayes</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DOCUMENT OF HEAVY - GAULINIC - 19

CERTIFICATE OF DESIGN

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	990	991	992	993	994	995	996	997	998	999	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1000	1001	1002	1003	1004	1005	1006	1007	1008	1009	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1010	1011	1012	1013	1014	1015	1016	1017	1018	1019	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1020	1021	1022	1023	1024	1025	1026	1027	1028	1029	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1030	1031	1032	1033	1034	1035	1036	1037	1038	1039	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1040	1041	1042	1043	1044	1045	1046	1047	1048	1049	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1050	1051	1052	1053	1054	1055	1056	1057	1058	1059	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1060	1061	1062	1063	1064	1065	1066	1067	1068	1069	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1070	1071	1072	1073	1074	1075	1076	1077	1078	1079	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1080	1081	1082	1083	1084	1085	1086	1087	1088	1089	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1090	1091	1092	1093	1094	1095	1096	1097	1098	1099	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1100	1101	1102	1103	1104	1105	1106	1107	1108	1109	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1110	1111	1112	1113	1114	1115	1116	1117	1118	1119	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1120	1121	1122	1123	1124	1125	1126	1127	1128	1129	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1130	1131	1132	1133	1134	1135	1136	1137	1138	1139	1140	1141	1142	1143	1144	1145	1146	1147	1148	1149	1140	11
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12103

## CERTIFICATE OF DEATH

12080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie</i>		d. STREET ADDRESS <i>101 Garrett Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>101 Garrett Road</i>				d. STREET ADDRESS <i>101 Garrett Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Adam</i>	Middle <i>Hiller</i>	Last <i>Taylor</i>	4. DATE OF DEATH	Month <i>December</i>	Day <i>7</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/31/1883</i>	9. AGE (In years last birthday) <i>75</i>	IP UNDER 1 YEAR yrs. <i>75</i>	IF UNDER 24 HRS. Months <i>0</i>	Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Civil Engineer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Engineer</i>		11. BIRTHPLACE (State or foreign country) <i>London, England</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>James Taylor</i> <del>XXXXXX</del>		14. MOTHER'S MAIDEN NAME <i>Deans Miller</i> <del>XXXXXX</del>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-01-0309</i>		17. INFORMANT <i>Robert E. Taylor 101 Garrett Road</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO (b)	<i>Septicemia &amp; septic shock</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>		
		DUE TO (c)	<i>Septicemia &amp; septic shock due to atherosclerosis</i>		<i>1 month</i>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 19.) <i>At hospital</i>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <i>Nov 16, 1956</i> , to <i>Dec 7, 1956</i> , that I last saw the deceased alive on <i>Dec 5, 1956</i> , and that death occurred at <i>6 a.m.</i> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>1318 Brandywine Street, Ellicott City, Maryland</i>							
DATE SIGNED <i>12/8/56</i>							
ACTUAL SIGNATURE <i>P.B. Hubbard</i>							
PHYSICIAN'S NAME (Type) <i>Howard E. Hubbard</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>12/10/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard E. Hubbard</i>		ADDRESS <i>4107 Wilkens Avenue</i>	24a. REC'D BY REGISTRAR DATE <i>DEC 10 1956 L.J. DeBary</i>				
			24b. REGISTRAR'S SIGNATURE				

## CERTIFICATE OF DEATH

RECEIVED  
BUREAU V. S.  
DEC 10 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12081

Reg. Dist. No. 27

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort G. G. Meade</b>		c. LENGTH OF STAY IN lb <b>3 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Army Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>BLANCHE</b>	Middle —	Last 4. DATE OF DEATH <b>THOMPSON</b> December 31 1956
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 29, 1920</b> 9. AGE (In years last birthday) 36 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk-Typist</b> 11. BIRTHPLACE (State or foreign country) <b>U.S. Civil Serv. Gleyida, Virginia</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>C. W. Dinsmore</b>		14. MOTHER'S MAIDEN NAME <b>Mary Redwine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes Navy</b>		16. SOCIAL SECURITY NO. <b>220-01-1477</b>	17. INFORMANT <b>Omer R. Dinsmore, Brother, Box 176, Route 17, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>330X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Aneurysm, Sudden</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Hours</b>	
(b) DUE TO <b>Aneurysm, Sudden</b>		<b>II</b>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <b>GUSTAVE H. FAUBERT</b>	31 Dec 56		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 7/57</b>	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <b>Glen Haven Cem.</b>	22d. LOCATION (City, town, or county) <b>Glen Burnie Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. J. Singletary</i>	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE DEC 31, 56 W. E. Saylor, 1st Lt., MSC		

RECEIVED EXAMINER'S CERTIFICATE OF DEATH  
CALIFORNIA STATE DEPARTMENT OF HEALTH - SAN FRANCISCO

NAME	ADDRESS	DEATH DATE
WILLIAM V. PURFARU	1111 18th Street, San Francisco, Calif.	February 1, 1957
CAUSE OF DEATH		
Diseased heart		
TIME OF DEATH		
11:00 A.M.		
PLACE OF DEATH		
At home		
TESTIMONY		
None		
EXAMINER'S SIGNATURE		
John C. Smith		
EXAMINER'S TITLE		
Medical Examiner		
EXAMINER'S ADDRESS		
1111 18th Street, San Francisco, Calif.		
EXAMINER'S PHONE NUMBER		
455-1234		

JAN 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

12082

Reg. Dist. No.

12105

1. PLACE OF DEATH a. COUNTY <i>A. A. Pt. Pleasant</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Glenelg</i>		c. LENGTH OF STAY IN 1b <i>10 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 238 - Furnace Ave</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pt. Pleasant</i>	
3. NAME OF DECEASED (Type or print) <i>Wm</i>		First <i>Henry</i>	Middle <i>Thompson</i>
		Last <i>H.</i>	DATE OF DEATH <i>Dec 18</i>
4. SEX <i>m</i>	5. COLOR OR RACE <i>w</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>6/20/70</i>
8. AGE (In years last birthday) <i>86</i>	9. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	10. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Crabber</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sold vegetables Baltimore Md.</i>	
10c. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		11. CITIZEN OF WHAT COUNTRY? <i>I.R.C.</i>	
13. FATHER'S NAME <i>Wm H. Thompson Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Woods</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Kathleen Finan - (same)</i>		Address	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. { DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6 AM</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>12/18/56</i> , 19 <i>56</i> , to <i>12/18/56</i> , 19 <i>56</i> that I last saw the deceased alive on <i>12/18/56</i> , 19 <i>56</i> , and that death occurred at <i>6 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Chas. L. Bell</i>		ADDRESS (Street, city or town, state) <i>Port Republic Md.</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>12/18/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Casket Keel</i>	22b. DATE THEREOF <i>12-21-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Casket Keel</i>	22d. LOCATION (City, town, or county) <i>Baltimore</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kathleen Finan</i>		ADDRESS <i>Same</i>	24a. REC'D. BY REGISTRAR DATE <i>DEC 19 1956</i>
			24b. REGISTRAR'S SIGNATURE <i>L. J. DeMille</i>

CERTIFICATE OF DEATH

DECEASED

DEATH CERTIFICATE

REGISTRATION

RECEIPT

SEARCH

INDEX

FILE

STAMP

RECEIVED

SEARCHED

INDEXED

FILED

STAMP

BUREAU A.

DEC 20 1956

RECEIVED

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS A15C-155 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**12083  
24**CERTIFICATE OF DEATH**

Reg. Dist. No.....

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY	Anne Arundel	STATE	Maryland
CITY (If outside corporate limits, write RURAL or end give nearest town)	MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY Anne Arundel
TOWN	Glen Burnie	TOWN	Glen Burnie
HOSPITAL OR INSTITUTION OR STREET ADDRESS	LENGTH OF STAY (in this place) 10 yrs.		
#8 Wilson Blvd., S.W.		STREET ADDRESS (If rural give location) #8 Wilson Blvd., S.W.	
<b>3. NAME OF DECEASED</b> (First) Wilbert T. Travers, Sr. (Type or Print)		<b>4. DATE OF DEATH</b> Dec. 8, 19 56	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Dec. 11, 1893
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk (ret.)		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.	9. AGE last birthday 63 yrs.
13. FATHER'S NAME Robert A. Travers		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
16. SOCIAL SECURITY NO. --		14. MOTHER'S MAIDEN NAME Isabel Adams	
17. INFORMANT & ADDRESS Marguerite M. Travers. #2 Same As		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		IMMEDIATE CAUSE (A) Carcinoma of the lung, right with ANTECEDENT CAUSE(S) DUE TO Metastasis DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE DUE TO _____ STATING UNDERLYING CAUSE LAST. (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
M. et work		21e. INJURY OCCURRED While Not while et work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6/13/19 55 to 12/8/19 56, that I last saw the deceased alive on 12/8/19 56, and that death occurred at 3: P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state) DATE SIGNED	
Burial		Glen Burnie, Maryland 12/8/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF Dec. 12/56	NAME OF CEMETERY OR CREMATORIAL Glen Haven
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE L. J. Sedlak	LOCATION (City, town, or county) (State) Glen Burnie, Maryland
DATE DEC 11 1956		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	
L. J. Sedlak		Tichy P. Singler, Jr., Glen Burnie Md.	

THE UNITED STATES GOVERNMENT OF THE STATE OF ALABAMA

CERTIFICATE OF DEATH

Receiv'd by

and enclosed is a copy of the

Death Certificate of

Deceased

Dec'd

Age

Sex

Color

Marital Status

Occupation

Employer

Address

City

State

Country

Religion

Education

Health

Family

Friends

Neighbors

Employers

Doctors

Attorneys

Bankers

Businessmen

Others

BUREAU V. S.

DEC 11 1950

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12107 CERTIFICATE OF DEATH

12084  
*24*

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>		c. LENGTH OF STAY IN lb <b>19 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>#110 Second Ave., S.W.</b>		d. STREET ADDRESS <b>#110 Second Ave., S.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Martha M. Upton</b>		First	Middle	Last	4. DATE OF DEATH <b>December 13, 1956</b>	Month	Day	Year
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1880</b>	9. AGE (In years lost birthday) <b>76 yrs.</b>	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Herman Duberke</b>		14. MOTHER'S MAIDEN NAME <b>Agusta Lux</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Reuben W. Upton</b>		Same As #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Acute Vascular Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>		
(b) DUE TO <b>Acute Vascular infection</b>						<b>10 days</b>		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b> </b>						
20c. TIME OF INJURY Hour a. m.      p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b> </b>		20f. (City or town) <b> </b>		(County)      (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <b>James S. Billingslee</b>								ADDRESS (Street, city or town, state) <b>Glen Burnie, Md.</b>
								DATE SIGNED <b>Dec 14, 1956</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 17, 1956</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Glen Haven</b>		22d. LOCATION (City, town, or county) <b>Glen Burnie</b>		(State) <b>Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Billingslee</b>		ADDRESS <b>Glen Burnie, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 18 1956</b>		24b. REGISTRAR'S SIGNATURE <b>L. J. Deallay</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

DEC 17 1956

**REFUGEE**

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12085

12108

## CERTIFICATE OF DEATH

Reg. Dist. No. *nt*

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gibson Island</i>		c. LENGTH OF STAY IN 1b <i>4 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Magothy Road</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Gibson Island</i>	
3. NAME OF DECEASED (Type or print) <i>Robert</i>		First _____	Middle _____
4. STREET ADDRESS <i>Van Iderstine</i>		Last _____	DATE OF DEATH <i>Dec. 30 1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 29, 1888</i>
9. AGE (In years last birthday) <i>58 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>Robert Van Iderstine</i>	14. MOTHER'S MAIDEN NAME <i>Ethel Skinner</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>wife - Louise</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial infarction</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>	
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arteriosclerotic Heart Disease years.		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 3 1956</i> , to <i>Dec. 30 1956</i> , that I last saw the deceased alive on <i>Dec. 30 1956</i> , and that death occurred at <i>3:57 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Kathleen H. Lyons</i> ADDRESS (Street, city or town, state) <i>Paisley Rd, Gibson Island, Md.</i> DATE SIGNED <i>12/30/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>Jan. 2, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>N.J. &amp; N.Y. Cremation Co</i>
22d. LOCATION (City, town, or county) <i>North Bergen</i>		(State) <i>N.J.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck, Inc. 5305 Harford Rd.</i>		24a. REC'D. BY REGISTRAR <i>JAN 2 1957</i>	24b. REGISTRAR'S SIGNATURE <i>H. J. Ruck</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12055 CERTIFICATE OF DEATH**

12087

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) USNH		c. LENGTH OF STAY IN 1b 30 Min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. Naval Hospital, Annapolis, Md.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS	
3. NAME OF DECEASED (Type or print) First Edwin Middle Bruce Last WATTS		d. STREET ADDRESS 1305 Stevens Avenue	
4. DATE OF DEATH December 3 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE Cau.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-96
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S.N. Retired		10b. KIND OF BUSINESS OR INDUSTRY --	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nathan Peter WATTS		14. MOTHER'S MAIDEN NAME Ella Virginia KAEISER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. 218262876	
17. INFORMANT USNH Records		Address Annapolis, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 1 Hr $\frac{1}{2}$	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-3-56, 1956, to 12-3-56, 1956, that I last saw the deceased alive on 12-3-56, 1956, and that death occurred at 12:30 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>P. O. Geib</i>		M.D.	
PHYSICIAN'S NAME (Type) P.O. GEIB CDR MC USN		U.S.N.H. Annapolis, Md. 12-3-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/56	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue		24a. REC'D BY REGISTRAR DATE 12-6-56 1956	
		24b. REGISTRAR'S SIGNATURE <i>Dr. J. J. Lynch</i>	

## CERTIFICATE OF DEATH

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BUREAU V. S.  
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DEC 5 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12088 34
12109 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>P.O. Pasadena</b> c. LENGTH OF STAY IN lb <b>Life</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Same</b> b. COUNTY <b>Same</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Same</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Magothy Beach</b>					d. STREET ADDRESS <b>Same</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Cynthia Marie Willard</b>		First	Middle	Last	4. DATE OF DEATH <b>December 13th</b>		Month	Day	Year	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>11/23/56</b>			9. AGE (in years last birthday) yrs. <b>20</b>	IF UNDER 1 YEAR Months <b>20</b>	IF UNDER 24 HRS. Hours <b>20</b>	Min. <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Raymond William Willard</b>										14. MOTHER'S MAIDEN NAME <b>Claire Marie Hammel</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Mrs. R.W. Willard (mother)</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>527.2</b> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Infection of pulmonary tract</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO _____ DUE TO _____										INTERVAL BETWEEN ONSET AND DEATH <b>Few Hours.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.			Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <i>Gustave H. Faubert M.D.</i> EXAMINER'S NAME (Type) <b>Gustave H. Faubert M.D.</b>										DATE SIGNED <b>12/13/56</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 14/56</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Redeemer</b>			22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Smith</i> ADDRESS <b>Glen Burnie, Md.</b>										
24a. REC'D BY REGISTRAR <b>DEC 14 1956</b>					24b. REGISTRAR'S SIGNATURE <i>L.J. Hallip</i>					
24c. DATE <b>2040894-XV4</b>										

BUREAU Y. A.  
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DEC 14 1956